Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

August 17, 2023

[redacted], EX. VP OF MANAGER
CSW ARBOUR SQUARE IV DOYLESTOWN LP
[redacted]

RE: MERCER HILL AT DOYLESTOWN
2010 SOUTH EASTON ROAD
DOYLESTOWN, PA, 18901
LICENSE/COC#: 14872

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/13/2023, 04/14/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MERCER HILL AT DOYLESTOWN* **Licen e #**: *14872* **Licen e Expiration**: *02/18/2024*

Address: *2010 SOUTH EASTON ROAD, DOYLESTOWN, PA 18901*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone** [redacted] **Email**: [redacted]

Legal Entity

Name: *CSW ARBOUR SQUARE IV DOYLESTOWN LP*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I 2* **Date**: *10/20/2021* **I ued By**: *Township of Doylestown*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *65* **Waking Staff**: *49*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/14/2023*

Inspection Dates and Department Representative

04/13/2023 On Site [redacted]

04/14/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *97* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Gardner* **Capacity**: *26* **Residents Served**: *14*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

Diagnosed with Mental Illness: *26* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *17* **Have Physical Disability**: *33*

Inspections / Reviews

04/13/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/08/2023*

08/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/08/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *06/09/2023*

Inspections / Reviews *(continued)*

08/17/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/17/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

26b - Quality Management Plan Content

1. Requirements

2600.
26.b. The quality management plan shall address the periodic review and evaluation of the following:
1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated 01/07/2023 did not address reportable incident and condition reporting procedures, complaint procedures, staff person training, resident or family councils.

Plan of Correction ***Accept [redacted] - 05/11/2023)***

Mercer Hill at Doylestown will meet quarterly (or more frequently if deemed necessary by the General Manager) to review and evaluate the following areas: Reportable incident and condition reporting procedures, staff person training and Resident Council outcomes and citations/plans of corrections. 4-14-2023.

The Quality Management Plan will include the development and implementation of measures/interventions to address the areas identified as needing improvement. This process will include discussion of incident reports, tracking, trending and evaluating data, identifying concerns with the delivery of services and making changes as necessary as a result of the identification of the concern. Completed: 4-14-2023

The Quality Management Plan Policy and Procedure was reviewed and discussed with Department Head Managers. Department Head Managers will be expected to attend Quarterly Meetings and be prepared to discuss any concerns in their Departments; subsequent Action Plans and follow-up. An attendance form of participants will be taken at each meeting. Completed: May 2, 2022

The General Manager will be responsible for scheduling and conducting the Quarterly Quality Management Plan Meeting. The General Manager will be responsible for insuring that reportable incident and condition reporting procedures, staff person training, Resident Council outcomes, citations/plans of correction and other areas of departmental concerns are included and documentation is obtained. Quality Management Plan Meeting has been scheduled for: June 1, 2023.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented ([redacted] 08/17/2023)

82c - Locking Poisonous Materials

2. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A bottle of Tilex and Crest Toothpaste, with a manufacturer's label indicating "contact a Poison Control Center", was unlocked, unattended, and accessible in resident #1's room. Not all the residents of the home, including resident#1, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

Plan of Correction ***Accept (05/11/2023)***

The bottle of Tilex was returned to the locked housekeeping closet and the toothpaste belonging to resident 1 was secured. 4-13-232023

Mercer Hill at Doylestown will keep all poisonous materials including items labeled "seek medical attention if swallowed" or "contact poison control center if swallowed" locked and inaccessible to residents unless all of the residents living at Mercer Hill are able to safely use and avoid poisonous materials. Review of SDCU was completed. Any items that were identified as potentially poisonous were secured. Completed: 4-14-2023.

nservicing will be conducted for Housekeeping Staff, Med Techs and Caregivers.
Emphasis will be placed on the safe and secured storage of chemicals and other items with labels indicating "seek medical attention if swallowed" or "contact poison control center". Completion Date: 5-5-23

Housekeeping staff, Med Techs and Caregivers will be observant when entering resident rooms. Any items observed that are poisonous or potentially poisonous will be immediately removed and reported to their supervisor for nvestigation and appropriate intervention. Memory Care residents will have their own labeled storage containers for any personal care items that are potentially poisonous. These individual, covered containers will be stored in the ocked storage closet. Completed 5-3-2023. Any issues and concerns that are identified with this process will be reported by the supervisor at the Quality Management Meeting scheduled for June 1, 2023. Additional interventions as applicable will be discussed at that time. The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented - 08/17/2023)

103e - Left Overs

3. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated package of feta cheese, and package of carrots in the refrigerator.

Plan of Correction ***Accept - 05/11/2023)***

The unlabeled, undated package of feta cheese and package of carrots were immediately removed from the refrigerator and discarded. Completed: 4-14-2023.

To ensure that all left over food items were labeled and dated, the contents of all refrigerators, freezers and storage was reviewed by the Executive Chef. All items were labeled and dated. No issues or concerns were identified. Completed: 4-14-2023

All cooks/Dietary Aides will be inserviced relative to the importance of labeling and dating food items . Emphasis will be placed on the prevention of cross-contamination of food and use of expired food items. Date of Completion: 5-5-23

103e - Left Overs (continued)

The Executive Chef/Sous Chef or Cook will audit all refrigerators, freezers and storage daily x2 months to ensure all eft over food items are labeled and dated. Results of this daily audit will be recorded on an audit form. Any issues dentified will be corrected immediately.

Daily audit outcomes will be reviewed by the Executive Chef at the Quality Management Plan Meeting scheduled for June 1, 2023. Any ongoing issues identified will be discussed and additional interventions implemented. The General Manager will be responsible for continued compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented ([redacted] - 08/17/2023)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 4/14/23, there were prepared beans in the refrigerator with an expiration date 03/21/23.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

The prepared beans in the refrigerator with an expiration date of 3/21/2023 were immediately removed and discarded. Completed: 4-14-2023

Mercer Hill at Doylestown will not use any outdated, spoiled foods or food in dented cans. The Executive Chef audited all cans in dietary. No other dented cans were identified. Completed: 4-14-2023

The Executive Chef will inservice all cooks and dietary aides in reference to the policy and procedure for outdated food and dented cans. Completed: 5-5-2023

The Executive Chef/Sous Chef or Cook will audit all refrigerators/freezers/dry storage for expired foods daily x 2

103i - Outdated Food (continued)

months to insure all foods are either utilized or discarded by the expiration date. Any issues identified will will be corrected immediately. Daily audits will be reviewed by the Executive Chef at the Quality Management Plan Meeting scheduled for June . Any issues identified will be discussed and further interventions implemented as needed. Date of Completion: 6-1-23 The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented ([redacted] - 08/17/2023)

171c Home's Vehicle Documents

5. Requirements

2600.
171.c. The home shall maintain current copies of the following documentation for each of the home s vehicles used to transport residents:
1. Vehicle registration.
4. Current inspection.

Description of Violation

The home does not have a copy of current vehicle registration for its Ford Eldorado van used to transport residents.

Plan of Correction ***Accept[redacted] 05/11/2023)***

The Ford Eldorado Van now has a current vehicle registration dated 4-14-2023.

The additional vehicle used for resident transport had a valid vehicle registration located in the glove compartment. Completed: 4-14-2023.

A calendar reminder related to vehicle registration for both vehicles has been added to the General Manager's lap top. The vehicle registration will be completed by the General Manager when the calendar reminder appears. Once the vehicle registration has been submitted, the calendar reminder will be accepted and a date for the next year will be added. 4-14-2023

The General Manager will have the responsibility for implementing this process for both Community Vehicles. Any ssues identified with this process will be discussed at the Quality Management Plan scheduled for 6/1/2023

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Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented[redacted] - 08/17/2023)

182b - Prescription Medication

6. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:

182b - Prescription Medication *(continued)*

4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 04/01/23 at 6am-10am, staff person A administered medications to residents, of the home including resident 1, to include the following: [redacted]. Staff person A is not a staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

The team member Involved was immediately removed from passing medications. Health Services Director explained to team member why this action needed to occur. Completed; 4/14/2023.
The Health Services Director looked through all current medication technician documentation to ensure that documentation was within the regulatory time frames. This review identified no further concerns. Completed; 4/14/2023
On a quarterly basis and at time of new hire the Health Services Director will review all medication technician documentation to make sure it is within the time frames as per regulations. Any issues identified through this review will be corrected immediately. This will include medication administration observations and re education as applicable. Completed; To be completed quarterly beginning 4/14/2023.
The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Completed: to be completed June 1, 2023. The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented [redacted] - 08/17/2023)

183e - Storing Medications

7. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 04/14 at 3pm, Resident #2's medication [redacted] medication blister card had tape on one of the blisters to hold the pill in the blister card. The foil on the back of the pill was ripped, the home put tape on the back of the medication which is an unsanitary method of storing medications.

Plan of Correction ***Accept [redacted] - 05/11/2023)***

Upon discovery of this the Health Services Director and Resident Care Director inspected bingo card and destroyed medications that foil had been ripped and then taped over. Completed: 4/14/2023

The Health Services Director and Resident care director went through the bingo cards on each med cart (three in building) to ensure that foil was intact and no tape was on back of cards. Completed: 4/15/2023

183e - Storing Medications (continued)

The Health Services Director along with the Resident Care Director inserviced medication technicians that this is not allowed and that the medication must be destroyed and not taped back into bingo card pack, and report it to HSD. Completed: 5/4/2023.
A qualified representative from Polaris Pharmacy will observe the medication pass for each Med Tech to review for competency. Each Med Techs will be re-educated immediately if issues are identified. To be completed by: 5/19/2023

For a period of one month the Health Services Director or the resident care director will review medication carts weekly to ensure compliance and ensure infection control measures are being implemented. Date of Completion: 6/1/2023.
Outcomes of this review will be discussed at the QA management meeting. Additional interventions will be mplemented as needed. The General Manager will be responsible for compliance,

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented [redacted] - 08/17/2023)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 is prescribed [redacted], take one capsule by mouth every 12 hours. On 04/14/23 at 9am, Resident #2's medication administration record indicates medication was administered. The narcotic count sheet count did not have an entry for a decline in count for the administration. on 4/14/23 at 2:30pm, the medication blister package for [redacted] and the corresponding narcotic count sheet showed 27 pills left when the count should have decreased by one. Staff member B stated that resident#2 refused medication and the initial was a mistake on the administration record. Per resident#2 interview, resident#2 did not refuse to take this medication. On 4/14/23, the medication was not administered at 9am as ordered.

Plan of Correction ***Accept ([redacted] 05/11/2023)***

The resident was checked by the Health Services Director to see they were in pain upon discovery of the medication error. The resident did not exhibit any adverse effects of the medication error. The Health Services Director also reviewed EMAR and narcotic count book to confirm accuracy of medication administration. Completed; 4/14/2023.
The Health Services Director looked through the narcotic administration logs to ensure that documentation was accurate. This review identified no further concerns. Completed; 4/14/2023.
Re-education on proper medication administration and proper documentation when there is a refusal, along with the five rights to medication administration in-service will be given to all medication technicians along will all licensed nurses within one week. Completed; 04/20/23.
The Health Services Director/designee will review the medication administration record quarterly for the quarterly audits and will review results at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of completion: June 1, 2023.

Licensee's Proposed Overall Completion Date: *06/07/2023*

185a - Implement Storage Procedures *(continued)*

Implemented (08/17/2023)

187d - Follow Prescriber's Orders

9. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed [redacted] take one capsule by mouth every 12 hours. On 04/14/23 at 9am, Resident #2's medication administration record is initialed to indicate the medication was administered, however there is no decrease on the narcotic count sheet and the medication is still present in the medication card. When interviewed staff member B stated that resident#2 refused medication and they initialed the administration record by mistake, however, per resident#2 interview, resident#2 did not refuse to take this medication. On 4/14/23, the medication was not administered at 9am as prescribed.

Resident #3 is prescribed [redacted] apply one patch topically to back once daily (12 hours on at 9am, 12 hours off at 9pm). On 04/14/23 at 9:30 am during the medication pass, resident#3 there was a [redacted] present on their back. It was determined that the patch had not been removed at 9pm as prescribed the night before. The resident's MAR was signed as though it was removed at 9pm.

Repeat Violation date: 8/15/22

Plan of Correction ***Accept - 05/11/2023)***

Residents 2 and 3 were checked by the Health Services Director completed pain assessment on resident upon discovery of the medication error. The resident had no adverse effects of medication error. The Health Services Director also reviewed EMAR as well as the narcotic count book to confirm accuracy of medication administration. Completed; 4/14/2023.
The Health Services Director looked through the narcotic administration logs to ensure that documentation was accurate. This review identified no further concerns. Completed; 4/14/2023.
Re-education on proper medication administration and proper documentation when there is a refusal, along with the five rights to medication administration in-service will be given to all medication technicians along will all licensed nurses within one week. Completed; 04/20/23.
The Health Services Director/designee will review the medication administration record quarterly for the quarterly audits and will review results at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of Completion: June 1, 2023. The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented 08/17/2023)

188b - Medication Error Reporting

10. Requirements

188b - Medication Error Reporting *(continued)*

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

On , at , during medication's audit, it was noted that resident #2 is prescribed . However, resident #2 was not administered Xtampza ER Cap 9mg on /23 at . The medication error was not reported to the resident, and prescriber.

Plan of Correction ***Accept (- 05/11/2023)***

Mercer Hill will immediately report a medication error to the resident, residents designated person and the prescriber. Completed: 4-14-2023.

The medication error relative to Resident #2 was reported on 4-14-2023 at 5pm to the resident, resident designated person and the Attending Physician. No new orders.. The report was faxed on the same day to DHS. Completed: 4-14-2023

All medication errors will be reported to the resident, resident designated person and the prescriber immediately. The Health Services Director will have the responsibility to ensure this process is implemented. Any identified issues with the implementation of this process will be discussed at the Quality Management Plan meeting scheduled for June 1, 2023 for follow-up and additional interventions if applicable. The General Manager is responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented - 08/17/2023)

190a - Completion Medication Course

11. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who has not successfully completed the Department-approved medications administration course, administered medications to residents to include the following:
On /23 at , Staff A administered

Plan of Correction ***Accept (- 05/11/2023)***

The team member Involved was immediately removed from passing medications. Health Services Director explained to team member why this action needed to occur. Completed; 4/14/2023.
The Health Services Director looked through all current medication technician documentation to ensure that the documentation present was within the regulatory time frames. This review identified no further concerns. Completed; 4/14/2023
On a quarterly basis and at time of new hire, the Health Services Director will review all medication technician documentation to make sure it is within the time frames as per regulations. Any issues identified through this

190a - Completion Medication Course (continued)

review will be corrected immediately. This will include medication administration observations and re education as applicable. Completed; To be completed quarterly beginning 4/14/2023.
The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of Completion: June 1, 2023.
The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented (- 08/17/2023)

224a Preadmission Screen Form

12. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department s preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 4's preadmission screening form, dated 23, does not include a determination that the needs of the resident can be met by the services provided by the home.

Repeat Violation Date: 8/15/22

Plan of Correction ***Accept (- 05/11/2023)***

The Health Services Director upon discovery of pre admission screening error had compared PAS paper to the electronic copy that was done on Yardi. That is when the Health Services Director had discovered that there was a deviation in the computer checking the box on the printed pre admission screening stating that services can be provided by the home. The Health Services Director also contacted the Health Services Systems Manager to make them aware of the deviation in the system. Completed; 04/14/2023
The Health Services Director audited charts within the personal care and secured memory support unit for any further occurrences of this occurring. Completed; 04/20/2023
On a quarterly basis the Health Services Director will review all Pre-admission screenings and new admissions to make sure all fields are completed as per regulations. Any issues identified through this review will be corrected immediately. This will include audits of resident medical charts quarterly and as needed. Completed; To be completed quarterly beginning 06/01/2023.
The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of Completion: June 1, 2023.
The General Manager will have responsibility with Compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented (- 08/17/2023)

227d Support Plan Medical/Dental

13. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident 2 has and uses and enabler bar. Resident #2's assessment and support plan, dated [redacted]/23, does not include the residents need or ability to use an enabler bar.

The assessment for resident #4, dated [redacted]/23, indicates the resident has a need for eating, managing health care, shopping, securing transportation and managing finances. The resident's support plan, dated 03/29/23 does not document how these needs will be met.

Plan of Correction ***Accept ([redacted] 05/11/2023)***

The Health Services Director, upon discovery of the support plan error, compared the electronic copy that was done on Yardi. That is when the health services director discovered that there was a deviation in the computer with additional details. The Health Services Director also contacted the Health Services Systems Manager to make them aware of the deviation in the system. Completed; 04/14/2023.

The Health Services Director along with the Resident Care Director audited charts within the personal care and secured memory support unit for any further occurrences. Completed; 04/20/2023.

On a quarterly basis the Health Services Director along with the Resident Care Director will review support plans for reevaluations and new admissions to make sure all fields are completed as per regulations. Any issues identified through this review will be corrected immediately. This will include audits of resident medical charts quarterly and as needed. Completed; To be completed quarterly beginning 06/01/2023.

The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of Completion: June 1, 2023.

The General Manager will be responsible for compliance.

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented [redacted] - 08/17/2023)

228h - Grounds Discharge/Transfer

14. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

3. If a home determines that a resident s functional level has advanced or declined so that the resident s needs cannot be met in the home. If a resident or the resident's designated person disagrees with the home s decision to discharge or transfer, consultation with an appropriate assessment agency or the resident's physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department s personal care home regional office.

228h - Grounds Discharge/Transfer *(continued)*

Description of Violation

On [redacted]/23, resident 5 was sent to the hospital for vomiting and diarrhea. On [redacted]/23, the home discharged resident 5 against the resident's will and and not for any of the permitted reasons. On [redacted]/23, while the resident remained in the hospital the home issued a letter to resident 5 indicating a discharge from the home effective immediately and that they could not return to the home following hospital discharge. The letter indicated that the immediate discharge was due to a change in the residents condition however, the home failed to obtain a physician's evaluation or certification indicating that the resident's functional level has advanced or declined so that the resident's needs cannot be met in the home.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

Resident #5 was discharged from Mercer Hill at Doylestown on April 7, 2023, due to care needs that could not be met at the Community.

As of April 7, 2023 no other residents have been discharged from Mercer Hill at Doylestown.

Mercer Hill at Doylestown will only discharge or transfer a resident for the following conditions.: Resident is a danger to themselves or others; If the legal entity chooses to voluntarily close the Community or portion of the Community; f this Community determines that a resident's care level has advanced or declined so the needs cannot be met in this community; If meeting a resident's needs would require a fundamental alteration in the building site, or would place an undue financial or programmatic burden on the Community; If the resident has failed to pay after reasonable documented evidence by the home to obtain payment; If closure of the home is initiated by the Department; or documented, repeated violation of the home rules. The General Manager, in conjunction with the Health Services Director and Resident Care Director will act as a team in order to ensure that a 30 day discharge is provided and a reason is referenced for discharge as permitted by Regulation 228h. If the resident's family disagrees with the Community's decision to discharge or transfer, the General Manager, Health Services Director or Resident Care Director will involve an appropriate assessment agency or request the resident's physician provide documentation determining the resident's need for a higher level of care. In addition, the General Manager, Health Services Director or Resident Care Director will work with the resident's family or Responsible Party to plan for placement in another Community and to also involve additional community support if assistance with relocation is needed. Documentation will be kept in the Resident's clinical record by the Health Services Director or Resident Care Director of all measures, interventions and communications made throughout the discharge process. Completed: 4-14-2023

The General Manager will have the responsibility of reviewing documentation daily throughout the discharge process more frequently, if applicable) with the Health Services director and Resident Care Director to ensure regulations are followed and communication between Community staff, resident and/or responsible party, Physician and Community agencies are documented. Any measures not followed will be corrected immediately and documented. This procedure will be implemented for all discharges. Any issues identified with the discharge process will be mmediately corrected and discussed by the General Manager at the Quality Management Plan scheduled for June 1, 2023. The General Manager will be responsible for compliance.

228h - Grounds Discharge/Transfer (continued)

Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented (08/17/2023)

234b Support Plan Needs Elements

15. Requirements

2600.
234.b. The support plan must identify the resident s physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated , for resident #1 does not address eating, managing health care, doing laundry, shopping, and other personal care need and degree has not been addressed.

The support plan, dated , for resident #5 does not address medical physical and mental diagnosis as well as eating, ambulating, managing health care, doing laundry, shopping, and other personal care need and degree has not been addressed.

Repeat Violation Date: 8/15/22

Plan of Correction ***Accept (- 05/11/2023)***

The health Services Director, upon discovery of the support plan error, compared the electronic copy that was done on Yardi. That is when the Health Services iDrector discovered that there was a deviation in the computer with additional details. The Health Services Director also contacted the Health Services Systems Manager to make them aware of the deviation in the system. Completed; 04/14/2023.
The Health Services Director along with the resident care director audited charts within the personal care and secured memory support unit for any further occurrences. Any additional details to be added into support plans by hand written to ensure compliance. Completed; 04/20/2023.
On a quarterly basis the Health Services Director along with the resident care director will review support plans for reevaluations and new admissions to make sure all fields are completed as per regulations. Any issues identified through this review will be corrected immediately. This will include audits of resident medical charts quarterly and as needed. Completed; To be completed quarterly beginning 06/01/2023.
The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of completion: June 1, 2023.
The General Manager will have the responsibility for compliance

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Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented - 08/17/2023)

234c Support Plan Responsible Person

16. Requirements

234c - Support Plan Responsible Person *(continued)*

2600.
234.c. The support plan must identify the individual responsible to address the resident's needs.

Description of Violation

The support plan, dated [redacted]/23, for resident #1 does not identify the individual responsible for addressing the resident's needs, including eating, managing health care, doing laundry, shopping, transportation, and managing finances.

The support plan, dated [redacted]/23, for resident #5 does not identify the individual responsible for addressing the resident's needs, including eating, ambulating, managing health care, doing laundry, and shopping.

Plan of Correction ***Accept ([redacted] - 05/11/2023)***

The Health Services Director, upon discovery of the support plan error, compared the electronic copy that was done on Yardi. That is when the health services director discovered that there was not a identified individual responsible listed. The Health Services Director also contacted the resident care director to this concern. Completed; 04/14/2023.
The Health Services Director along with the resident care director audited charts within the personal care and secured memory support unit for any further occurrences. Completed; 04/20/2023.
On a quarterly basis the Health Services Director along with the resident care director will review support plans for reevaluations and new admissions to make sure all fields are completed as per regulations. Any issues identified through this review will be corrected immediately. This will include audits of resident medical charts quarterly and as needed. Completed; To be completed quarterly beginning 06/01/2023.
The Health Services Director/designee will review the results for the quarterly audits at the quality management plan meeting. If needed additional interventions will be discussed and implemented. Date of Completion: June 1, 2023. The General Manager will be responsible for compliance.
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Licensee's Proposed Overall Completion Date: *06/07/2023*

Implemented ([redacted] - 08/17/2023)