

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

August 24, 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 06/06/2023, 06/07/2023, 06/08/2023 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 **License #:** 14872 **License 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: 1 2 **Date:** 10/20/2021 **Issued By:** Township of Doylestown

Staffing Hours

Resident Support Staff: **Total Daily Staff:** 72 **Waking Staff:** 54

Inspection Information

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

Reason: Complaint **Exit Conference Date:** 06/08/2023

Inspection Dates and Department Representative

06/06/2023 On Site [REDACTED]

06/07/2023 On Site [REDACTED]

06/08/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 97 **Residents Served:** 58

Secured Dementia Care Unit

In Home: Yes **Area:** Garden House **Capacity:** 26 **Residents Served:** 10

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 58

Diagnosed with Mental Illness: 28 **Diagnosed with Intellectual Disability:** 0

Have Mobility Need: 14 **Have Physical Disability:** 35

Inspections / Reviews

06/06/2023 - Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 07/06/2023

Inspections / Reviews *(continued)*

07/07/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/22/2023

08/24/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/22/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED], Staff Member A refused to push Resident # 1 in their wheelchair to the dining room, telling the resident they would have to eat dinner in their room because they were too large to push.

On [REDACTED]. Staff Member A failed to clean and change a resident who had dried feces and urine on their person. The home did not report these incidents to the Department.

Plan of Correction

Accept [REDACTED] - 07/07/2023)

Mercer Hill at Doylestown will report an incident or condition to DHS regional office or PCH hotline with 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in 2600.15, Staff member A was terminated from employment at Mercer Hill on 5/23/2023. Incidents occurring on 5/20/23 and 2/28/2023 were reported to DHS by the Health Services Director on the "Reportable Incident and Condition Form" on June 6, 2023.

All Community Incident Reports and 24 hour reports were reviewed from June 1, 2023 to current date July 5, 2023. Based on this review, the Health Services Director determined that no other incidents needed to be reported to the DHS Regional Office.

2600.16c and Appendix A (Reportable Incidents) in the Regulatory Compliance Guide were reviewed with Administrative Staff. Copies of this regulation was distributed to administrative staff for reference. An opportunity for questions and clarification of reportable events were provided. Administrative staff indicated they were understanding of incidents/conditions that require reporting to Regional DHS. Completed: 7/5/2023

All Community Incident Reports on the Yardi reporting program and Community 24 hour report forms will be reviewed daily by the Health Services Director/Resident Care Director/Designee for DHS reporting potential. Incidents that require reporting will be completed by the Health Services Director/Resident Care Director within the required timeframe. All incidents reported will be reviewed at the Quality Assurance Meeting scheduled for August 21, 2023. Any issues identified will be corrected immediately. The Health Services Director will be responsible for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [REDACTED] - 08/24/2023)

18 - Compliance With Laws

2. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

On [REDACTED] and on [REDACTED], after 1:00 PM, no staff present in the kitchen were ServSafe certified. The PA Department

18 - Compliance With Laws (continued)

of Agriculture Food Employee Certification Act, 3 Pa C.S.A. 6501 – 6510, effective January 22, 2011, requires one employee per licensed food facility to obtain a nationally recognized food manager certification. National exam programs are those that have been approved by ANSI using the Conference of Food Protection certified food protection manager standards. The Food Employee Certification Act requires one supervisory employee per food facility to obtain a food safety certification by taking an ANSI-CFP nationally recognized food safety class. The certified employee must be available during all hours of operation. The certified employee is the Person-in-Charge (PIC) when in the facility.

Plan of Correction

Accept [REDACTED] - 07/07/2023)

Mercer Hill at Doylestown will comply with PA Department of Agriculture Food Employee Certification Act requiring 1 employee per licensed food facility to obtain a nationally recognized Food Manager Certification. The Food Employee Certification Act also requires one supervisory employee per food facility to obtain a food safety certification by taking a ANSI-CFP nationally recognized food safety class. Certified employee must be available during all hours of operation.

Cooks and Sous Chef will be enrolled in a ServSafe program in order to obtain the necessary credentialing. Date of Completion 8/14/2023.

The Executive Chef will be responsible to oversee the enrollment of those dietary employees in a ServSafe program. Once obtained, ServSafe certifications will be posted in the dietary department. Dates of expiration will be recorded by the Executive Chef to ensure timely recertification.

The Executive Chef will review outcomes of this process at the Quality Assurance Meeting scheduled for August 21, 2023. Any issues or concerns will be discussed and changes made accordingly. The Executive Chef will be responsible for overall compliance with the regulation

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [REDACTED] - 08/24/2023)

23a - Activities of Daily Living Assistance

3. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #2's monthly task log for [REDACTED] 2023 indicates the resident requires assistance with personal hygiene, bowel and bladder management, ambulating, and toileting. On [REDACTED], the resident did not receive this assistance as required.

Resident #3's monthly task log for [REDACTED] 2023 indicates the resident requires assistance with dressing and personal hygiene. On [REDACTED], the resident did not receive this assistance as required.

Resident #4's monthly task log for [REDACTED] 2023 indicates the resident requires assistance with ambulating. On [REDACTED], the resident did not receive this assistance as required.

23a - Activities of Daily Living Assistance (continued)

Resident #5 has a [redacted] impairment. Their support plan states they require prompting/cueing with transferring in and out of bed or a chair, toileting, and personal hygiene. Their monthly task log for [redacted] 2023 indicates the resident requires assistance with personal hygiene, ambulating, toileting, transferring, and putting lotion on their extremities. On [redacted] the resident did not receive this assistance as required.

Interviews with staff and residents, complaints from family members, and disciplinary letters from management all confirm that these tasks have been missed.

Plan of Correction

Accept [redacted] 07/07/2023)

Mercer Hill at Doylestown will provide each resident with assistance with ADL's as indicated in the resident's assessment and support plan. Residents 2,3,4,5 had their assessments and support plan reviewed. All information document was correct.

The Health Services Director audited the task logs to identify any other residents who did not have documentation of services rendered as per resident assessment and support plan. This audit revealed that further inservicing to direct care staff is necessary to ensure that tasks are completed timely and documentation is accurate.

nservicing will be provided by the Health Services Director to all caregivers and med techs on July 6 or July 10, Alternate date) relating to the importance of documenting in the task log at end of shift. Emphasis will also be placed on charting codes and documenting an explanation on the Monthly Task Log if a task was refused or not completed.

Task logs will be reviewed by the Health Services Director/Resident Care Director/Designee daily.

Any issues identified with the daily review will be addressed with the staff person involved for immediate correction/explanation. Ongoing issues with staff members will be addressed with re-education and possible disciplinary action up to and including termination. The daily review will continue x3 months. Thereafter, 1x weekly for 3 months. Outcomes of the daily reviews will be discussed at the Quality Assurance Meeting scheduled for August 21, 2023. The Health Services Director will have responsibility for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [redacted] - 08/24/2023)

23b - Instrumental Activities of Daily Living Assistance

4. Requirements

2600.

23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #2's monthly task log for [redacted] 2023 indicates the resident requires assistance with bedmaking, reminders of social and leisure activities, dressing, transferring, showering, and TED hose assistance. On [redacted], and [redacted], the resident did not receive assistance with these tasks as required.

23b - Instrumental Activities of Daily Living Assistance (continued)

Resident #5's monthly task log for [redacted] indicates the resident requires assistance with being escorted to meals and an exercise class. On [redacted] the resident did not receive this assistance as required.

Plan of Correction

Accept [redacted] - 07/07/2023)

Mercer Hill at Doylestown will provide each resident with assistance with IADL's as indicated in the resident's assessment and support plan. Resident 2 and Resident 5 assessments and support plans were reviewed. Assistance levels with IADL's is correct.

The Health Services Director audited the task logs to identify any other residents who did not have documentation of services rendered as per resident assessment and support plan. This audit revealed that further inservicing to direct care staff and med techs is necessary to ensure that all IADL tasks are completed timely and documentation is accurate.

inservicing will be provided by the Health Services Director to all caregivers and med techs on July 6 or July 10 (alternate date), relating to the importance of documenting in the task log at the end of shift. Emphasis will also be placed on charting codes and documenting an explanation on the Monthly Task log if a task was refused or not completed.

Task logs will be reviewed by the Health Services Director/Resident Care Director/Designee daily. Any issues identified with the daily review will be addressed with the staff person involved for immediate correction/explanation. Ongoing issues with staff members will be addressed with re-education and possible disciplinary action up to and including termination. The daily review will continue daily x3 months. Thereafter, 1x weekly for 3 months. Outcomes of the daily reviews will be discussed at the Quality Assurance Meeting scheduled for August 21, 2023. The Health Services Director will have responsibility for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [redacted] - 08/24/2023)

42b - Abuse

5. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Reports from residents' family members, interviews with staff and residents, call bell logs, daily task logs, medication records, and disciplinary letters all indicate that residents' needs are not being met. A lack of staff has led to excessive waiting and missed tasks in assisting activities of daily living, as well as several instances of rudeness and neglect.

Resident #5 has a [redacted] impairment and requires daily assistance with personal hygiene, ambulating, toileting, transferring, and applying lotion to their extremities. On [redacted] the resident did not receive this assistance as required. On [redacted] Resident #5 was locked outside on the patio, unable to return to their room or use the bathroom for approximately an hour while they waited a response to their call bell. The log shows the resident was using and resetting their call bell repeatedly. Resident #5 also waited for 13 minutes and 30 seconds (13:30) on [redacted] 15:43 on [redacted], 17:45 on [redacted] and for two hours and one minute on [redacted] Resident # 5 was also was given their medications late on [redacted]

42b - Abuse (continued)

Call bell logs confirm that residents who need assistance from staff face excessive wait times, often exceeding the home's policy of a 12-minute limit. Resident #6's call bell rang for 23 hours and 23 minutes overnight between [REDACTED] and [REDACTED]. Resident #7 waited 53:55 on [REDACTED] and then for 6 hours and 42 minutes on [REDACTED]. Others have gone without the assistance they require with toileting, ambulating, personal hygiene and other needs of daily living, including residents # 2, # 3, # 4, and # 5.

Plan of Correction

Accept [REDACTED] - 07/07/2023)

Residents will not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Call Bell logs have been reviewed and residents have been identified who are now checked by staff every 2 hours to address any needs. The every 2 hr check has been included on each resident's support plan and has been entered into each resident's task log.

Task logs have been audited by the Health Services Director to identify any other residents who did not have documentation of services rendered as per resident assessment and support plan. Audit revealed that additional training and education to caregivers is necessary to ensure accurate and timely documentation.

EMAR has been reviewed by the Health Services Director. Audit identified issues with documentation of late medications.

The Health Services Director/Designee will randomly activate a resident's pendant daily x1 month to ascertain the staff response time. Any issues identified will be addressed with the staff person involved.

Until further notice, the Health Services Director/Designee will review the call bell logs daily and investigate any response time greater than 12 minutes.

Task logs will be reviewed by the Health Services Director/Resident Care Director/Designee daily x3 months, then 1xweekly for 3 months. Any identified issues will be addressed with the staff person involved.

EMAR documentation will be reviewed daily, x3 months then 1xweekly for 3 months by the Health Services Director/Resident Care Director. Incidents of late or missed administration of medication will be investigated with the staff person involved.

Additional pagers and walkie radios will be purchased as needed in order to ensure each caregiver has operational equipment available to them at all times.

Inservicing will be provided by the Health Services Director/Resident Care Director to all caregivers and med techs on July 6 or July 10 (alternate date) relating to accurate documentation on the task logs at end of shift, call bell response times, and documentation of late medication administration on the emar.

Health Services Director/Designee will ensure the scheduling of staff to meet resident's needs. Caregiver/med tech schedules will be completed 1 month in advance to ensure there is appropriate caregiver/med tech coverage for each shift. The Health Services Director/Designee will will conduct a daily review of the schedule to make certain that the appropriate med techs and caregivers are scheduled for the following day. This process will be completed at least 1 day in advance. In the event that a shift is not covered, available staff will be contacted and asked for coverage. The Health Services Director and Resident Care Director will provide coverage if a need exists. The General Manager/Designee will continue to hire full time, part-time and per-diem staff to fill caregiver/med tech vacancies.

Interventions for completion of task logs, call bell response times, Emar documentation and hiring outcomes will be discussed at the Quality Assurance Meeting scheduled for August 21, 2023. The Health Services Director will have

42b - Abuse (continued)

the responsibility for ongoing compliance.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented (████) 08/24/2023)

42c Treatment of Residents

6. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On █████/23, Staff Member A refused to push Resident # 1 in their wheelchair to the dining room for dinner and told the resident they must eat dinner in their room because they were too large to push in their wheelchair. On or around █████/23, Staff Member A failed to change another resident who had feces and urine on their person.

On █████3, Staff Member B exhibited rudeness and discourtesy by removing a resident's medications from the resident's room without explanation.

Residents stated in interviews that some staff members are brusque and seem in a hurry.

Plan of Correction

Accept █████ - 07/07/2023)

Staff members will treat all residents, regardless of age, disability, or behavior, with dignity and respect. Staff member A was terminated from employment on 5/23/23. Staff member B was terminated from employment on 4/21/2023.

Upon investigation, any staff member, found to be treating a resident without dignity and respect will receive an intervention including re-education and disciplinary action up to and including termination of employment.

Inservicing will be provided by the Health Services Director/Resident Care Director to all caregivers and med techs on July 6 or July 10, (alternate date) Method of inservicing will be participatory and include reviewing resident rights relative to dignity and respect, role play, return demonstration and discussion. Emphasis will also be placed on staff reporting any inappropriate behavior/interventions to their Supervisor for follow-up investigation. During this inservice, caregivers and med techs will be given the opportunity to have their questions answered and clarified. In addition, the Community Social Worker will randomly select 5 residents/week x 3 months to interview them on their experiences at Mercer Hill at Doylestown. Any issues identified during these interviews will be investigated and the necessary intervention(s) provided.

Any identified issues with the reporting and interview process will be discussed at the Quality Assurance Meeting scheduled for 8/21/2023. Any necessary revisions to this procedure will be discussed at that time Maintaining overall compliance with this regulation will be the responsibility of the General Manager.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented █████ - 08/24/2023)

42m - Resident Leave/Return

7. Requirements

2600.

42.m. A resident has the right to leave and return to the home at times consistent with the home rules and the resident's support plan.

Description of Violation

On [redacted]/23, Resident #5 was denied the right to reenter their room while locked outside on the patio. After the front doors close each night, someone from the staff must press a buzzer to unlock the doors. Due to a lack of staff, direct caregivers are left to man the front desk in the midst of their other duties. Resident #5 used their call bell without a response before calling their daughter, who was able to reach the front desk to ask for someone to let resident # 5 back in the room and assist them with using the bathroom. The call bell log from [redacted] shows resident # 5 was using and resetting their call bell repeatedly. The resident had wait times of 14 minutes and 27 seconds (14:27) and 13:20, as well as several alarms that received no response.

Interviews confirmed that other residents have been locked out while staff was occupied.

Plan of Correction

Accept [redacted] - 07/07/2023)

A resident has the right to leave and return to Mercer Hill at Doylestown at times that are consistent with the Community policies and the resident's support plan.

As of June 8, 2023, there have been no further reported issues with gaining entrance into the building.

Caregivers and med techs will be inserviced on July 6 or July 10 (alternative date) pertaining to call bell response times. In addition, emphasis will be placed on locating the resident if a call bell is activated when a resident is not in their room and to also reset the call bell pendant once the staff person enters the room.

Front doors are programmed to lock at 8pm. In order to gain access to the building after 8pm, the individual must ring the door bell located in the entranceway. A sign directing individuals to ring the door bell after 8pm is located at the entrance. After 8pm, the med tech carries the night phone. If the night phone is activated, a picture of the person waiting to gain access to the building is shown on the phone. The staff person may unlock the door from the phone by pressing the unlock prompt. The night phone will unlock the front door from any location in the building.

In addition, telephone calls received after 8pm are answered via night phone by the med tech. All overnight staff will continue to be inserviced on night phone use by the General Manager/Designee. To be completed by 8/1/2023.

Each new hire on the overnight shift will also be inserviced on night phone use by the General Manager/Designee.

Random 10p to 6a visits will be performed 3x/week for 1 month by the General Manager/Designee to ascertain compliance with this procedure. To be completed by 8/10/2023

Any resident/family complaints will be monitored by the social worker and immediately addressed with the staff person involved. Overnight visits by the General Manager/Designee will also be reviewed.

Outcomes will be discussed at the Quality Assurance Meeting scheduled for 8/21/2023. Additional interventions will be put into place at that time if applicable. General Manager will have responsibility for ongoing compliance

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [redacted] - 08/24/2023)

60a - Staff/Support Plan

8. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

Resident # 5's support plan states [REDACTED] requires prompting/cueing with transferring in and out of bed or a chair, toileting, and personal hygiene. On [REDACTED], the resident did not receive this assistance as required.

Daily task logs, resident interviews, complaints from residents' family members, call bell logs, medication records, incident reports, and disciplinary letters all indicate that residents needs are not being met due to a lack of available direct care staffing in the home. On 5/10/23, the average response time to a call ball was 23 minutes and 35 seconds. Resident # 6's call bell rang for 23 hours and 23 minutes overnight between [REDACTED]. Resident # 7 waited 53:55 on [REDACTED] and then for 6 hours and 42 minutes on [REDACTED].

The staffing schedule for [REDACTED] shows there was only one staff person working as a Medication Technician from [REDACTED] AM to [REDACTED] PM and from [REDACTED] PM to [REDACTED] AM on [REDACTED]. There were only two people working as caregivers during this [REDACTED] PM to [REDACTED] AM shift.

Interviews indicate that there is sometimes one medication technician and one caregiver covering the entire personal care unit of more than 60 residents, including fourteen residents who have mobility issues, needing additional staff to meet their needs. Medication administrations have been late due to the medication technician being unable to administer all of the resident's medications in the required timeframes. On [REDACTED] Residents # 2, # 3, # 4, and # 5 did not receive the assistance they require from staff with activities of daily living.

Plan of Correction

Accept [REDACTED] - 07/07/2023)

Mercer Hill at Doylestown shall provide staffing to meet the needs of the residents as specified in the Resident's Assessment and Support Plan.

The Caregiver/Med tech schedule will be completed at least 1 month in advance by the Health Services Director to make certain that there are caregivers and med techs scheduled to accommodate the care and medication needs of our residents per the Resident Assessment and Support Plan.

The Health Services Director/Designee will conduct a daily review of the schedule to make certain that there are sufficient med techs/licensed nursing staff/caregivers, scheduled for the following day. This process will be conducted at least 1 day in advance. In the event a shift is not covered, available med techs/caregivers will be contacted and asked for coverage. If none are available Wellness administration will cover the schedule. The General Manager/Designee will continue to hire full-time, part-time, per-diem staff to fill any caregiver/med tech vacancies.

Any concerns relating to this process will be discussed at the weekly GM/HSD/RCD meeting for additional interventions and solutions. Outcomes will be reviewed at the Quality Assurance Meeting scheduled for August 21, 2023. The Health Services Director will have the responsibility of overall compliance.

Licensee's Proposed Overall Completion Date: 09/01/2023

60a - Staff/Support Plan (continued)

Implemented [redacted] 08/24/2023)

63a - First Aid/CPR Training

9. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On [redacted]/23, sixty-three personal care residents were present in the home. During this time there was one staff person present in the home who was certified in first aid and CPR.

On [redacted] 23, fifty-four personal care residents were present in the home. During this time no staff persons present in the home were certified in first aid and CPR.

On [redacted]/23, sixty-four personal care residents were present in the home. During this time there was one staff person present in the home who was certified in first aid and CPR.

Plan of Correction

Accept [redacted] - 07/07/2023)

At least 1 staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

A list of all staff currently certified in CPR and obstructed airway techniques (with dates of expiration) is maintained by the Resident Care Director. The Resident Care Director is certified to teach CPR/First Aid.

Any newly hired staff will be asked to provide their current CPR certification. New hires without a current certification will be scheduled by the Resident Care Director to participate in a class. The Resident Care Director will have weekly trainings through the month of July to ensure that there is adequate number of CPR trained staff as per regulation. (Complete by 7/31/2023). All CPR certifications will be filed in a CPR binder in the Resident Care Director's Office. The RCD will be responsible for keeping the CPR certifications current and will schedule any additional trainings as needed.

The Resident Care Director will discuss any concerns related to this procedure at the Quality Assurance Meeting scheduled for August 21, 2023. Any revisions to this protocol will be implemented as necessary.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [redacted] - 08/24/2023)

141a 1-10 Medical Evaluation Information

10. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

- 141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #4's medical evaluation, dated [REDACTED]/2022, did not include a medical diagnosis.

Plan of Correction

Accepted [REDACTED] - 07/07/2023)

All residents will have a Medical Evaluation by a physician, physician's assistant or CRNP documented on a form specified by the Department within 60 days prior to admission or within 30 days after admission. The evaluation will include: physical exam by physician, physician's assistant, or NP, medical diagnosis, medical information pertinent to diagnosis, health and dietary special needs, allergies, immunization history, medication regime, contraindications, side effects and ability to self administrate, body positioning, health status and mobility assessment. The Medical Evaluation for Resident 4 dated 12/14/2022, did not include a medical diagnosis.

All resident's medical evaluations were reviewed by the Health Services Director for completeness including the medical diagnosis. The outcome of this review identified no other DME's without a diagnosis attached. Completed: 7/1/2023.

The Health Services Director/Resident Care Director will review all current and incoming DME's for inclusion of necessary information. This review will occur prior to filing the DME in the resident's clinical record. Any issues identified will be corrected immediately between the Health Services Director and the Primary Care Physician.

identified issues will be discussed at the Quality Assurance Meeting scheduled for 8/21/2023. Any necessary revisions to this procedure will be discussed at that time. Maintaining compliance will be the responsibility of the Health Services Director

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [REDACTED] - 08/24/2023)

141b2 Medical Evaluation Changes

11. Requirements

2600.

141.b.2. A resident shall have a medical evaluation: If the medical condition of the resident changes prior to the annual medical evaluation.

Description of Violation

141b2 - Medical Evaluation Changes (continued)

Resident #4 was hospitalized with a stroke on [REDACTED]/23. A new medical evaluation was not completed with this change in the resident's medical condition.

Plan of Correction

Accept [REDACTED] 07/07/2023)

All residents at Mercer Hill at Doylestown will have a new medical evaluation completed if the medical condition of a resident changes prior to the annual medical evaluation.

As of 6/6/2023, all residents with changes in medical conditions have had a new medical evaluation completed. Completed 7/1/2023.

The Health Services Director/Resident Care Director were inserviced by the General Manager relating to the conditions when a new DME is necessitated. Both the Health Services Director and the Resident Care Director indicated their understanding of the information presented and when a new DME should be obtained. Completed: 6/6/2023

Any identified issues with this procedure will be discussed at the Quality Assurance Meeting scheduled for 8/21/2023. Any necessary revisions to this procedure will be discussed at that time. Maintaining overall compliance with this regulation will be the responsibility of the Health Services Director.

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [REDACTED] - 08/24/2023)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident # 2 is prescribed [REDACTED], take one every night at bedtime. An administration time of 9pm is indicated on the Medication Administration Record (MAR) On [REDACTED] 23, this medication was not administered until [REDACTED] pm

Resident # 4 is prescribed [REDACTED] take one tablet by mouth daily. An administration time of 9am is indicated on the Medication Administration Record (MAR). On [REDACTED]/23, this medication was not administered until [REDACTED] am. On [REDACTED]/23, this medication was not administered until [REDACTED] am. On [REDACTED]/23, this medication was not administered until [REDACTED] am

Resident # 5 is prescribed [REDACTED] [REDACTED] An administration time of [REDACTED] to [REDACTED] is indicated on the Medication Administration Record (MAR). However, resident # 5 was administered [REDACTED] on [REDACTED]/23 at [REDACTED] AM.

Plan of Correction

Accept [REDACTED] 07/07/2023)

All residents will have their medications administered as prescribed by the physician.

187d - Follow Prescriber's Orders (continued)

A nursing schedule will be completed at least 1 month in advance to make certain that there is a Med Tech available to administer medications in the Community for each shift.

The Health Services Director/designee will conduct a daily review of the schedule to make certain that Med Techs are scheduled for the following day. This process will be conducted at least 1 day in advance. In the event that a shift is not covered with the appropriate amount of med techs, available med techs will be contacted and asked for coverage. Nursing Administration will fill in as needed to administer medications. This process will be ongoing. The GM will continue to hire Med Techs for position vacancies.

Any concerns relating to this process will be discussed at the weekly GM/HSD/RCD meeting for any additional interventions and solutions. Outcomes of this meeting will be discussed at the Quality Assurance Meeting scheduled for August 21, 2023. The Health Services Director will have responsibility for maintaining overall compliance

Licensee's Proposed Overall Completion Date: 09/01/2023

Implemented [REDACTED] - 08/24/2023)