

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

February 12, 2024

[REDACTED], ADMINISTRATOR
FREDERICK MENNONITE COMMUNITY
2849 BIG ROAD - OFFICE
ZIEGLERVILLE, PA, 19492

RE: FREDERICK LIVING - ASPEN VILLAGE
2849 BIG ROAD
ZIEGLERVILLE, PA, 19492
LICENSE/COC#: 13258

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/20/2023, 09/22/2023 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: *FREDERICK LIVING - ASPEN VILLAGE* License #: *13258* License Expiration: *07/22/2024*
 Address: *2849 BIG ROAD, ZIEGLERVILLE, PA 19492*
 County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *FREDERICK MENNONITE COMMUNITY*
 Address: *2849 BIG ROAD OFFICE, ZIEGLERVILLE, PA, 19492*
 Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *C 2 LP* Date: *04/19/2000* Issued By: *CWOPA Dept of L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *40* Waking Staff: *30*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Incident* Exit Conference Date: *09/21/2023*

Inspection Dates and Department Representative

09/20/2023 On Site: [REDACTED]
 09/22/2023 Off Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *31* Residents Served: *20*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Entire Home* Capacity: *31* Residents Served: *20*

Hospice
 Current Residents: *3*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *20*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *20* Have Physical Disability: *0*

Inspections / Reviews

09/20/2023 - Full
 Lead Inspector: [REDACTED] Follow Up Type: *POC Submission* Follow Up Date: *10/12/2023*

Inspections / Reviews *(continued)*

10/19/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/12/2023

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/24/2023

10/27/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/24/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/27/2023

02/12/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/05/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [REDACTED], resident 1 rammed a walker into an unnamed resident. This incident was reported to staff person A on [REDACTED] at approximately [REDACTED] and documented in the resident's progress notes. However, this allegation of abuse was not reported to the local area agency on aging.

On [REDACTED] at approximately [REDACTED] resident 2 was heard screaming. Staff persons B, C and D witnessed resident 2 come out of resident 1's room holding their left thigh and saying "ow" repeatedly. The staff members also witnessed resident 1 scowling at resident 2. This allegation of abuse was not reported to the local area agency on aging until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 10/27/2023)

1. On 9/18/23 PCHA provided education regarding incident procedures to all team members involved in [REDACTED] incident.
2. PCHA or designee will audit team member training records for 2023 year to ensure completion of regularly scheduled Abuse Training by 10/15/23.
3. PCHA or designee will provide team member education regarding Abuse reporting by 10/15/23.
4. PCHA or designee will provide quarterly Abuse reporting education at regularly scheduled team meetings. PCHA or designee will audit at time of incident and on a monthly basis all abuse allegations to ensure proper reporting to conclude 12/31/2023.

Proposed Overall Completion Date: 12/31/2023

Proposed Overall Completion Date: 11/15/2023

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented ([REDACTED] - 02/12/2024)

16c - Written Incident Report

2. 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] resident 1 rammed a walker into an unnamed resident. This incident was reported to staff person A on [REDACTED] approximately [REDACTED] and documented in the resident's progress notes. The home did not report this incident to the department.

16c Written Incident Report (continued)

On [REDACTED] at approximately [REDACTED], resident 2 was heard screaming. Staff persons B, C and D witnessed resident 2 come out of resident 1's room holding their left thigh and saying "ow" repeatedly. The staff members also witnessed resident 1 scowling at resident 2. The home did not report this incident to the department until [REDACTED]

Plan of Correction

Accept ([REDACTED] - 10/27/2023)

1. On 9/18/23 PCHA provided education regarding incident procedures to all team members involved in [REDACTED] incident.
2. PCHA or designee will audit team member training records for 2023 year to ensure completion of regularly scheduled Abuse Training by 10/15/23.
3. PCHA or designee will provide team member education regarding Abuse reporting by 10/15/23.
4. PCHA or designee will provide quarterly Abuse reporting education at regularly scheduled team meetings. PCHA or designee will audit at time of incident and on a monthly basis all abuse allegations to ensure proper reporting to conclude 12/31/2023.

Proposed Overall Completion Date: 12/31/2023

Proposed Overall Completion Date: 11/15/2023

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented ([REDACTED] - 02/12/2024)

42b - Abuse

3. 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

On [REDACTED] at approximately [REDACTED], resident 2 was in resident 1's room. Staff persons B, C and D heard a scream come from the room and witnessed resident 2 leave the room holding their left thigh and repeatedly saying "ow". Staff persons B, C and D also witnessed resident 1 scowling at resident 2. As a result of what happened in the room, resident 2 has a bruise on the left thigh. There is nothing in resident 1's room that poses a hazard if bumped into. Resident 1's file documents a history of aggressiveness towards staff and other residents and staff report that resident 1 often displays aggression, however, resident 1's most recent assessment and support plan was not updated to address the need or a plan to meet the resident's behavioral need.

Plan of Correction

Accept ([REDACTED] - 10/19/2023)

1. On [REDACTED] residents were immediately separated and assessed for any clinical care needed. On 9/18/23 interdisciplinary team review of the incident was completed, resident 1 provided with a stop sign for her accommodation and resident 2 assessed by nurse practitioner. On [REDACTED] resident 1 was assessed by hospice provider and medication adjustments were completed.
2. PCHA or designee will complete a resident RASP review to ensure aggressive behaviors are appropriately documented for all residents applicable by 10/31/2023.
3. PCHA or designee will provide team member education regarding aggressive behaviors and appropriate

42b Abuse (continued)

interventions by 10/31/2023.

4. As of 10/01/2023 all new RASP forms for current residents will be completed in electronic format and printed for team and resident review annually, with any change in condition, and upon department request.

Proposed Overall Completion Date: 10/31/2023

Licensee's Proposed Overall Completion Date: 10/31/2023

Implemented (redacted) - 02/12/2024)

65a - FS Orientation 1st Day

4. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was (redacted), did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat Violation: 9/13/22 et al

Plan of Correction

Accepted (redacted) - 10/19/2023)

1. Agency Orientation in place on 10/6/23.
2. PCHA or designee will audit agency team member records for 2023 year to ensure completion of Agency Orientation by 10/15/2023.
3. PCHA or designee will provide Agency Orientation to all outstanding agency team members by 10/31/2023.
4. PC DON or designee will provide Agency Orientation assignment for all new agency team members. PCHA or designee will audit completion biweekly to conclude 11/30/2023.

Proposed Overall Completion Date: 11/30/2023

Licensee's Proposed Overall Completion Date: 11/30/2023

Implemented (redacted) - 02/12/2024)

65f - Training Topics

5. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident, care for residents with dementia and cognitive impairments during training year 2022.

Plan of Correction

Accept (█ - 10/19/2023)

1. PCHA confirmed Staff Person B has completed trainings as outlined in 65.f.(1)(2)(3)(4)(7) for the 2023 calendar year on █. Trainings pursuant to 65.f.(5)(6) to be assigned by █.
2. PCHA or designee will audit team member records for 2023 to confirm completion of required trainings and/or assign required trainings. Audit to be completed by █.
3. Team member required trainings will be completed by 80% of team members by █.
4. PCHA, Staff Development Team Member, and/or designee will develop 2024 training plan to include all required training areas by 10/31/2023.

Proposed Overall Completion Date: 11/15/2023

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented (█ - 02/12/2024)

65g - Annual Training Content

6. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a

65g - Annual Training Content (continued)

fire safety expert during training year 2022.

Plan of Correction

Accept ([REDACTED] - 10/27/2023)

1. PCHA confirmed Staff Person B has not yet completed in-person fire safety training for the 2023 calendar year. Training to be scheduled by 11/15/2023.
2. PCHA or designee will audit team member records for 2023 to confirm completion of in-person fire safety training and/or assign in-person fire safety training. Audit to be completed by 10/15/2023.
3. Team member in-person fire safety training will begin 10/20/2023 with the expectation of 100% completion by 12/31/2023.
4. PCHA, Staff Development Team Member, and/or designee will develop 2024 training plan to include all required training areas by 10/31/2023.

Proposed Overall Completion Date: 12/31/2023

Proposed Overall Completion Date: 11/15/2023

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented ([REDACTED] 02/12/2024)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

- 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

The resident 1's medical evaluation dated [REDACTED] did not include medication regimen.

Plan of Correction

Accept ([REDACTED] - 10/19/2023)

1. On 09/20/2023 PCHA confirmed Resident 1's Medical Evaluation and electronic medical record dated 0 [REDACTED] do not include medication regimen.
2. PCHA or designee will audit all current residents' most recent Documentation of Medical Evaluation forms for completeness and inclusion of medication regimen by 10/15/2023.
3. Team member education to be provided regarding documentation management and electronic process for Documentation of Medical Evaluation forms by 11/15/2023.
4. As of 10/01/2023 all new Documentation of Medical Evaluation forms for current residents will be completed in electronic format and printed for physician verification imbedding the medication regimen directly into the document itself reducing the need for attachments.

Proposed Overall Completion Date: 11/15/2023

141a 1 10 Medical Evaluation Information *(continued)*

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented () - 02/12/2024)

225c - Additional Assessment

8. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident 1's assessment, dated (), does not include an appropriate assessment for aggression. Progress notes indicate aggressive behavior on () and a new assessment was not completed.

Repeat Violation: 9/13/22 et al.

Plan of Correction

Accept () - 10/19/2023)

1. On 09/20/2023 PCHA confirmed Resident 1's current RASP does not include aggressive behavior. Resident 1's RASP was updated on ().
2. PCHA or designee will audit all current residents' most recent RASP forms for completeness and documentation of behaviors with respective interventions by 10/31/2023.
3. Team member education to be provided regarding documentation management, electronic process for RASP forms and significant change characteristics by 11/15/2023.
4. As of 10/01/2023 all new RASP forms for current residents will be completed in electronic format and printed for team and resident review annually, with any change in condition, and upon department request.

Proposed Overall Completion Date: 11/15/2023

Licensee's Proposed Overall Completion Date: 11/15/2023

Implemented () - 02/12/2024)

233c - Key-Locking Devices

9. Requirements

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the courtyard in the Secure Dementia Care Unit (SDCU).

Plan of Correction

Directed () - 10/27/2023)

Code has been placed by courtyard doors for access with instruction. See attached.

Proposed Overall Completion Date: 10/24/2023

233c Key Locking Devices (continued)

Directed Plan of Correction:

Beginning withing 15 calendar days of the receipt of this plan of correction, PCHA or designee shall twice a month audit or monitor all electronic locking systems to ensure the directions for operation are posted conspicuously near the device. Audits shall continue twice a month for 3 months then once quarterly there after.

Directed Completion Date: 10/24/2023

Implemented [REDACTED] - 02/12/2024)