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

January 17, 2024

[redacted], MANAGER OF GENERAL PARTNER
CSW ARBOUR SQUARE V HUNTINGDON VALLEY, L.P.
[redacted]

RE: CRESCENT FIELDS AT
HUNTINGDON VALLEY
2507 PHILMONT AVE
HUNTINGDON VALLEY, PA, 19006
LICENSE/COC#: 15005

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/27/2023 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: *CRESCENT FIELDS AT HUNTINGDON VALLEY* **License #**: *15005* **License Expiration**: *06/28/2024*

Address: *2507 PHILMONT AVE, HUNTINGDON VALLEY, PA 19006*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *CSW ARBOUR SQUARE V HUNTINGDON VALLEY, L.P.*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *02/20/2023* **Issued By**: *Township of Lower Moreland*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal, Complaint, New* **Exit Conference Date**: *09/27/2023*

Inspection Dates and Department Representative

09/27/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *196* **Residents Served**: *28*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care Unit* **Capacity**: *18* **Residents Served**: *3*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *5* **Have Physical Disability**: *0*

Inspections / Reviews

09/27/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/29/2023*

11/29/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/17/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/02/2023*

Inspections / Reviews *(continued)*

01/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/13/2024*

01/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

01/17/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *01/17/2024*

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

65a - FS Orientation 1st Day

1. 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 persons A and B, whose first day of work was [redacted]/2023, did not receive orientation on the following topics:

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.

Staff person C, whose first day of work was [redacted]/2023, did not receive orientation on the following topics:

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.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate actions:

1. Staff re-training/training for all current employees has been scheduled for 12/5 and 12/7 to immediately address all PA State required trainings. (Business Office, ED)

2. Monthly new hire orientation will be held two times per month for any upcoming new hires. (All directors)

3. Power point slide specific to fire safety and emergency preparedness has been added the new hire orientation presentation (completed by ED)

4. Maintenance Director completed fire safety walk with employees who had not yet gone on a fire safety walk. (completed 11/14, 11/15 and 11/16)

5. New hires not permitted to begin work until scheduled to attend a new hire orientation session. (immediately and ongoing)

65a - FS Orientation 1st Day (continued)

Quality Improvement:
1. Slide specific to fire safety and emergency procedures was added to the orientation presentation to ensure proper training moving forward. (completed 11/24 by ED)
2.. All new hires to the community will receive orientation that includes general fire safety and emergency preparedness training, as well as a fire safety walk throughout the community. (Business Office Director and ED starting immediately and ongoing)
3. New hires to the community will not be permitted to start work until they have attended the general orientation. (Business Office Director to monitor beginning immediately and ongoing)

Responsible Parties:
Business Office Director:
Maintenance Director
Executive Director:
All Community Directors

Prevention of Recurrence:
1. New hire orientation will be held 2 times per month and will include all PA State required trainings for general fire safety and emergency preparedness.
2. All current employees were or will be educated/re-educated on general fire safety and emergency preparedness procedures for the community.
3. Business Office Director to schedule all new hires for general orientation that includes fire safety and emergency preparedness procedures as their first day of work. No new hire permitted to start prior to orientation.

see attached documents

Proposed Overall Completion Date: 12/31/2023

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

65b - Rights/Abuse 40 Hours

2. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff members A and B completed their 40th scheduled work hour on [redacted] 2023. However, this staff person did not complete training in the following topics:
1. Resident rights.
2. Emergency medical plan.

65b - Rights/Abuse 40 Hours (continued)

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Staff person C completed [redacted] 40th scheduled work hour on [redacted], 2023. However, this staff person did not complete training in the following topics:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. Staff re-training/training for all current employees has been scheduled for 12/5 and 12/7 to immediately address all PA State required trainings, including Resident Rights, Abuse reporting, and the Emergency Medical Plan. (Business Office, ED, HWD)
2. Monthly new hire orientation will be held on 12/14 and 12/28 for any upcoming new hires. (All directors)

Prevention of Recurrence and Monitoring :
1. All new hires to the community will be scheduled to receive orientation that includes resident rights, emergency medical plans, OAPSA and reporting of reportable incidents and conditions, prior to performing job duties. (Business Office and ED beginning immediately and ongoing)
2. New hires to the community will not be permitted to start work until they have attended the general orientation. (Business Office and ED immediately and ongoing)

Responsible Parties:
Business Office Director:
Health & Wellness Director:
Executive Director:
All Community Directors

see attached supporting documents

Proposed Overall Completion Date: 12/31/2023

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

66b - Training Plan Content

3. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
1. The name, position and duties of each direct care staff person.
2. The required training courses for each staff person.

66b - Training Plan Content *(continued)*

3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's staff training plan does not include the dates, times, and locations of the scheduled training for each staff member for the upcoming year.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. Staff re-training/training for all current employees has been scheduled for 12/5 and 12/7 to immediately address all PA State required trainings. (Business Office, ED)
2. Monthly new hire orientation will be held on 12/14 and 12/28 for any upcoming new hires. (All directors)
3. Once training is completed, Staff training plans for all current employees including the following, will be included into each employee record.
a.) The name, position and duties of each direct care staff person.
b.) The required training courses for each staff person.
c.) The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Quality Improvement:
1. Staff training plans of all new hires and for annual required trainings will include all the PA Personal Care Home specifications as noted in 2600.66.b (Business Office and ED, immediately and ongoing)
2. No new hire will be permitted to begin work until scheduled and attendance confirmed at New Hire Orientation. (Business Office and ED, immediately and ongoing)
3. Employee Orientation checklists will be signed by employee and trainers (directors) at time of completion and monitored for full completion by Business Office Director or ED. (immediately and ongoing)

Responsible Parties:
1. Executive Director:
2. Business Office Director:
3. other directors as assigned

Prevention of Recurrence:
1. Crescent Fields training plan consists of Distinctive Living General Orientation, State Mandatory Trainings, and Distinctive Living Annual trainings
2. Employees will sign in-service/training attendance sheets for each training they attend throughout the year. The required trainings will be transcribed onto the employees annual training records.
3. Employee training records will be maintained and entered into the employee file.

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

82c - Locking Poisonous Materials

4. Requirements

82c - Locking Poisonous Materials *(continued)*

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

Coconut hand soap, Tresemme hair spray, Suave body wash, and a bottle of deodorant with a manufacturer's label indicating "Keep out of the reach of children; please contact the poison control center", were unlocked, unattended, and accessible to resident 1. Not all the residents of the home, including resident 1, have been assessed as capable of recognizing and using poisons safely.

2 bottles of Dove cream, Dove bodywash, Gold Bond dry skin relief, and Colgate Toothpaste, with a manufacturer's label indicating "keep out of the reach of children, please contact poison control center", were unlocked, unattended, and accessible to resident 2. Not all the residents of the home, including resident 2, have been assessed as capable of recognizing and using poisons safely.

Cleansing wipes and Clear Moisture Barrier Ointment, with a manufacturer's label indicating "Keep out of the reach of children; please contact the poison control center", were unlocked, unattended, and accessible to resident 3. Not all the residents of the home, including resident 3, have been assessed as capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. All memory care resident apartments were checked for items considered poisonous and ensured those items were placed in locked cabinets in resident bathrooms. (completed by HWD and care staff)
2. All care staff educated/reminded to ensure items considered poisonous were locked in resident cabinet in bathroom following care. (completed by HWD 9/27/23 and ongoing)
3. All staff training scheduled for 12/5 and 12/7 to immediately address all PA State required trainings and training related to this plan of correction. (Business Office, ED, HWD)

Quality Improvement:
1. Weekly memory care apartment audits will be completed to ensure compliance with locking all poisonous materials in locked cabinet within the resident bathroom. (initiated week of 11/27 and ongoing; HWD and care staff)

Responsible Parties:
1. Health & Wellness Director:
2. Maintenance Director:
3. Executive Director:
4. Other staff members as assigned

Prevention of Recurrence:
1. All staff members to be re-educated on Pennsylvania regulation 2600.82c regarding locking of poisonous materials and preventing access to those materials by resident's incapable of utilizing them. (Business Office, ED, HWD; ongoing)
2. Staff members in memory care neighborhood will be re-educated on locking of all personal care items labeled by the manufacturer as "keep out of reach of children," in resident locked bathroom cabinets. (HWD, ED on 12/5 and 12/7, ongoing)
3. Weekly memory care apartment audits will be completed to ensure compliance with locking all poisonous materials in locked cabinet within the bathroom. (HWD and care staff; initiated week of 11/27 and ongoing)

82c - Locking Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

85e - Trash Outside Home

5. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 9/27/2023, there were approximately 9 wood pallets and a piece of metal behind the dumpsters.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate actions:
1. Pallets found left behind the dumpsters were removed by the Maintenance Director following inspection on 9/27/23.
2. Inservice provided to kitchen and Maintenance/Housekeeping staff initiated when citation received on 11/22/23 related to keeping dumpster area cleared of trash and storage. (ED; completed 12/1/23)

Quality Improvement:
1. Maintenance, Housekeeping and Kitchen staff training scheduled for 12/5 and 12/7 on the need to keep the dumpster area clean, picking up overflow and not storing items within that area. (Maintenance Director, ED)
2. First Impressions checklist to be created and implemented by 12/1/23 and will include monitoring of the dumpster area for any items that should not be stored there, covers on bins are down and no trash is noted surrounding the area. (E.D, All Directors)

Prevention of Recurrence:
1. No storage of any kind will be permitted around the dumpster area and will be monitored weekly for compliance with newly created first impressions checklist. (All directors; ongoing)

Responsible Parties:
1. Maintenance Director:
2. Culinary Director:
3. Executive Director:
4. Other employees as assigned

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

96a - First Aid Kit

6. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the facility bus does not include eye coverings, tweezers, or a thermometer.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate actions:

1. The home to order the necessary first aid kit materials that were missing from the facility bus including eye coverings, tweezers and thermometer and place them in the first aid kit by 12/6/23. (ED, Activities Director)

Quality Improvement & Prevention of Recurrence:

1. Activities Director will audit the bus first aid kit and create inventory list to attach to the kit for auditing purposes by 12/6/23.

2. Activity Director and/or Bus Driver will review the first aid kit inventory as part of the vehicle safety check to be completed each week. (Immediately and ongoing)- see attached.

Responsible Party:

1. Activities Director/Bus Driver

2. Executive Director:

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented ([redacted] - 01/17/2024)

97 - Elevators/Lifting Devices

7. Requirements

2600.
97. Elevators and Stair Glides - Each elevator and stair glide must have a certificate of operation from the Department of Labor and Industry or the appropriate local building authority in accordance with 34 Pa. Code Chapter 405 (relating to elevators and other lifting devices).

Description of Violation

Elevator #3 does not have a certificate of operation from the Department of Labor and Industry or an appropriate local building authority.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:

1. Elevator certificate was available and ready to be presented to surveyor prior to [redacted] departure at time of inspection but was not accepted. (RVP of HW on 9/27/23) see attached.

Quality Improvement and Prevention of Recurrence:

1. Certificate of operation for all elevators from the Department of Labor & Industry will be kept onsite and ready for review. (ED, Maintenance Director; immediately and ongoing)

2. Certificate of operation for all elevators will be kept in the State Survey Readiness binder as well as in the Maintenance Director's office for presentation at time of inspections (immediately and ongoing)

Responsible Parties:

97 - Elevators/Lifting Devices (continued)

Executive Director:
Maintenance Director:

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 01/17/2024)

101j7 - Lighting/Operable Lamp

8. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents 4, 5, and 6 do not have access to a source of light that can be turned on or off at the bedside.

Plan of Correction ***Accept ([redacted] - 12/07/2023)***

Immediate Actions:
1. Attempted to resolve issues with residents in apartments 4, 5, 6 but honored resident rights/choice to not have lamp at bedside. (HWD, RVP HW)
2. All resident apartments will be checked for a light source that can be turned on/off at bedside, by 12/22/23. (HWD, ED, Maintenance)
3. Flashlights, night lights or another form of light source to be offered to residents who choose to not have a lamp at bedside by 12/22/23 (HWD, ED, Maintenance)

Quality Improvement and Prevention of Recurrence:
1. All direct care staff and directors will be provided education on the Pennsylvania personal care home regulations 101j1 through 101l regarding required bedroom furniture and lighting source, in each apartment. (HWD, ED; scheduled for 12/5/23 and 12/7/23)
2. Families providing their own furniture will be educated on the Pennsylvania personal care home regulations 101j1 through 101l, at the time of agreement signing to ensure compliance with required furniture and lighting sources. (ED, Business Office, Sales Directors; immediately and ongoing)
3. Residents choosing not to have a lamp at bedside will be offered and required to have another source of lighting option ie. flashlight, nightlight to be kept at bedside. (HWD, ED, Maintenance- ongoing)

Responsible Parties:
1. Executive Director:
2. Health & Wellness Director:
3. Directors and direct care staff as assigned.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

103e - Left Overs

9. Requirements

103e - Left Overs *(continued)*

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 jar of grape juice on the 3rd floor kitchen in the refrigerator.

There were an unlabeled, undated box of croissants, two bags of chicken wings, a bag of potato fries, a bag of ravioli, and a pie in the main freezer in the main kitchen.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. All undated and not labelled items in all refrigerators were either removed or labelled immediately after discovered by surveyor on 9/27/23.
2. All kitchen staff were reminded of importance and requirement of labelling/dating food items in all refrigerators.

Quality Improvement and Prevention of Recurrence:
1. Kitchen staff inservicing on requirements of labelling/dating of food items was completed 11/22/23 through 11/26/23 (Culinary Director)
2. Staff re-training/training for all current employees has been scheduled for 12/5 and 12/7 to immediately address all PA State required trainings and trainings pertaining to State inspection deficiencies from 9/27/23 (Business Office, ED)
3. Daily audits will be completed at time of refrigerator/freezer temperature checks, to ensure compliance with labelling, dating and inspection of foods. (Culinary Director, Kitchen staff- immediately and ongoing)

Responsible Persons:
Culinary Director:
Executive Director:
Other culinary employees as assigned

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

103f - Refrigerator/Freezer Temps

10. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There was no thermometer in the freezer in the Memory Care Unit kitchenette.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. All refrigerators checked for presence of thermometers on 9/27/23. Thermometer was added to Memory Care

103f - Refrigerator/Freezer Temps (continued)

Unit refrigerator at time of inspection on 9/27/23.
2. Daily temperature logs were in place at all refrigerators and temperatures have been monitored from 9/27/23 and ongoing.

Quality Improvement and Prevention of Recurrence:
1. Kitchen staff inservicing on requirements of having a thermometer present and monitoring refrigerator/freezer temperatures per 2600.103f was completed 11/22/23 through 11/26/23 (Culinary Director)
2. Staff re-training/training for all current employees has been scheduled for 12/5 and 12/7 to immediately address all PA State required trainings and trainings pertaining to State inspection deficiencies from 9/27/23 (Business Office, ED, Culinary)
3. Daily audits will be completed for refrigerator/freezer temperatures, to ensure compliance with 2600.103f. (Culinary Director, Kitchen staff- immediately and ongoing)
4. Weekly audits to be completed to ensure daily temperatures are checked and logged daily on the tracking form. (Culinary Director- immediately and ongoing)

Responsible parties:
Culinary Director:
Executive Director:
Other Culinary employees as assigned

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

107b - Emergency Procedures

11. Requirements

2600.
107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include the contact information for each resident's designated person.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. Resident designated persons contact information started to be collected and entered into the community EHR starting 9/27/23 to populate on resident face sheets. (HWD completed on 11/24/23)
2. EHR restructuring to require entry of resident designated person contact information within the system was completed. (HWD on 11/24/23)

107b - Emergency Procedures (continued)

3. Business Office Director organized and placed all resident designated contact person information at the front desk for easy access in the event of emergencies. (Business Office- completed and ongoing)

Quality Improvement and Prevention of Recurrence:
1. Crescent Field's emergency procedures will include contact information for each resident's designated person kept at the front desk, secured resident chart, as well as in our electronic system for easy access in emergency situations (HWD, Business Office Director, ED- completed and ongoing)
2. Resident Clinical and Director of Sales/Marketing Admission Checklist will be initiated at daily stand-up meetings, for all new move-ins to the community to monitor compliance with resident designated contact information and ensure it is present for the community's emergency plan and resident record. (ED, HWD, DSM, Business Office- initiated 12/1/23 and ongoing)
3. All Resident Clinical and DSM checklists completed for new move-ins will be audited for full completion at the end of each month. (Business Office, ED- starting 12/1/23 and ongoing)

Responsible Parties:
1. Health & Wellness Director:
2. Director of Sales/Marketing
2. Business Office Director:
3. Executive Director:
4. Other employees as assigned

see attached supporting documents

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented [redacted] - 01/17/2024)

107c - Food/Water 3 Day Supply

12. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 9/27/2023, the home served 28 residents, requiring 84 gallons of emergency drinking water. However, the home had only 66 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction ***Accept ([redacted] - 12/07/2023)***

Immediate Actions:
1. Additional emergency water was ordered on 9/27/23 and received 9/30/23 (Culinary Director)
2. Due to resident count, additional emergency water was ordered on 11/23/23 and received on 11/25/23 to include 10% more than required. (Culinary Director)

Quality Improvement and Prevention of Recurrence:
1. Community will have 10% more emergency food/water for residents than required by Pennsylvania regulations by ordering and having in storage to cover any new move-ins (Culinary Director completed 9/27/23 and 11/25/23

107c - Food/Water 3 Day Supply (continued)

and ongoing)
2. The community will audit emergency food and water inventory monthly and compare to resident occupancy numbers to ensure 10% more than required is onsite. (Culinary Director, ED 11/25/23 and ongoing)

Responsible Parties:
1. Culinary Director:
2. Executive Director:
3. Other employees as assigned

Method:
1. Emergency food and water inventory sheets to be added to storage areas. (ED 11/24)
2. Emergency food and water inventory sheet to be audited monthly in relation to resident occupancy ensuring that the community has 10% more than required. (Culinary Director, ED 12/1/23 and ongoing)

see attached supporting documents

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented [redacted] - 01/17/2024)

131f - Fire Extinguisher Inspection

13. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

There were no inspection tags on the fire extinguisher that is on the facility bus.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. Bus fire extinguisher tag was found in the glove box and re-attached to the fire extinguisher. (Maintenance Director- completed 9/28/23)
2. Vehicle inspection checklist was created and placed in community vehicles. This checklist includes checking the fire extinguisher inspection dates. (ED completed on 11/24/23

Quality Improvement and Prevention of Recurrence:
1. Fire extinguisher inspection date audits are entered into TELS electronic compliance tracking system to provide reminders to Maintenance Director to complete inspection. (Maintenance director- immediate and ongoing)
2. Fire extinguisher on the community bus will be included in the community fire extinguisher inspection requirements. (ED, completed 11/24/23)
3. Vehicle inspection checklist including the community vehicle fire extinguisher inspections will be completed weekly. (Bus driver, Activities Director- initiated 11/27 and ongoing)
4. Monthly audit of vehicle inspection checklist compliance will be completed for two months. (Activity Director, ED- December 2023 and January 2024).

Responsible Parties:
1. Bus Driver/Activities Director

131f - Fire Extinguisher Inspection (continued)

2. Maintenance Director
3. Executive Director:
4. Other employees as assigned

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented (- 01/17/2024)

132a - Monthly Fire Drill

14. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of July for the entire facility. There were also no unannounced fire drills held during the month of August in the personal care unit.

Plan of Correction ***Accept (- 12/07/2023)***

Immediate Actions:
1. Maintenance Director found record of all fire drills/training performed by Croker Fire Professionals from July 2023 through present date that were referenced in this citation. These records were sent as part of this Plan of Correction. See attached documentation. (ED- completed 12/1/23)

Quality Improvement and Prevention of Recurrence:
1. Crescent fields will continue to hold monthly, unannounced fire drills, by a fire safety professional for all shifts. This will include any necessary training related to the findings of those drills. (Croker Fire Professionals, Maintenance Director, ED- Initiated June 2023 through present)
2. Records of fire drills and training performed by Croker Fire Professionals will be kept in Maintenance Director office and state survey readiness binder in ED's office to be readily available for state inspections. (Maintenance Director, ED- completed and ongoing.

Responsible Parties:
Maintenance Director:
Executive Director:
Other employees as assigned.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented (- 01/17/2024)

141a 1-10 Medical Evaluation Information

15. 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 7's medical evaluation did not include the medical information pertinent to diagnosis and treatment in case of an emergency.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:

1. All resident DME's were audited for compliance with 2600.141a 1-10 requirements. (DHW completed 11/24)

Quality Improvement and Prevention of Recurrence:

1. Upon acceptance to Crescent Fields, the Resident Clinical and Director of Sales/Marketing Admission Checklist will be initiated at daily stand-up meetings, for all new move-ins to the community to monitor compliance with DME completion (ED, Sales, HWD, Business Office- 12/1/23 and ongoing).

2. All Resident Clinical and DSM checklists completed for new move-ins will be audited for full completion at the end of each month. (Business Office, ED- starting 12/1/23 and ongoing)

3. Resident will not be permitted to move into an apartment until all required documents are received and audited for compliance to Pennsylvania regulations. (ED, HWD immediately and ongoing)

Responsible Parties:

1. Health & Wellness Director:

2. Executive Director:

3. Other employees as assigned.

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

162c - Menus Posted

16. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

162c - Menus Posted *(continued)*

Description of Violation

The home's menu for the week of 10/01/2023 to 10/07/2023 was posted. However, the menu for the current week of 9/24/2023 to 9/30/2023 was not posted in a public and conspicuous place throughout the facility.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:

1. The community serves meals restaurant style both in Personal Care and Memory support. Always available food offerings were posted for breakfast, lunch and dinner in the Personal Care Dining room and the Memory Support neighborhood. Those items are available every day. (Culinary Director- completed 9/27/23)

2. Daily special menus are posted daily in the Personal Care dining room and Memory support neighborhood in restaurant style. (Culinary Director, Kitchen staff- completed)

Quality Improvement and Prevention of Recurrence:

1. Crescent Fields will conspicuously post an always available monthly menu stating specific foods being available at each meal, throughout the Personal Care and Memory support parts of the community. (Culinary Director- 12/6/23 and ongoing)

Responsible Party:

1. Culinary Director:

2. Executive Director:

3. Other employees as assigned

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

171c - Home's Vehicle Documents

17. 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.
2. Valid driver's license for vehicle operator.
3. Vehicle insurance.
4. Current inspection.
5. Commercial driver's license for vehicle operator if applicable.

Description of Violation

The home does not have a copy of the driver's license in good standing for the person who operated the vehicle used to transport residents.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:

1. Driver license of the community vehicle driver was provided to surveyor on day of survey, 9/27/23. (RVP HW)

2. Driver licenses of current community drivers was obtained and included in employee record for easy access at time of state inspection. (ED completed 11/24/23)

171c - Home's Vehicle Documents (continued)

Quality Improvement and Prevention of Recurrence:
1. All required vehicle documents will be copied and placed in the community's survey readiness binder for easy review during community inspections. (ED- completed 11/24 and ongoing)
2. Copies of all community driver, vehicle related information will be placed in the business office records as a safeguard against misplaced or outdated information. (ED, Business Office- completed 11/24/23 and ongoing)
3. At time of renewal or change in vehicle documentation, copies of updated documents will be placed in the survey readiness binder and the business office file. (ED, Business Office- 12/1/23 and ongoing)

Responsible Parties:
1. Executive Director:
2. Activities Director:
3. Business Office Director:

see attached supporting documents

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

183e - Storing Medications

18. 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 9/27/2023, 2 packs of Clonazepam Tab 0.5 mg prescribed for resident 8 were in a blister card. The foil on the back of two of the pills had ripped open.

On 9/27/2023, Oxycodone Tab 20 mg prescribed for resident 9 was in a blister card. The foil on the back of one of the pills had ripped open.

Plan of Correction ***Accept [redacted] - 01/16/2024)***

Immediate Corrective Action:
• Medication Carts in PC and MC were immediately audited on 11/21/2023 following receipt of the results of the licensing survey.
• Any Bingo cards that had the label "package has been altered by the pharmacy" were pulled out of medication cart to be returned to MMP Pharmacy. (see attached picture)

Long Term Quality Improvement Actions:
1. MMP Pharmacy has updated their process to immediately replace any tampered with packaging or has any evidence of damage going forward. (see attached letter from MMP detailing process)
Completion Date: 1/11/2024
Responsible Party:
MMP- will ensure and manage their process of sending no tampered with medication packaging to the community.

183e - Storing Medications (continued)

Community Medication Assistants- will continue to be diligent in their medication check-in process and report immediately any tampered packaging to their DHW.
DHW- Responsible for ensuring that all processes are followed.
2. Community Nursing/CMA Staff will continue to be diligent in their medication check-in process and report immediately any tampered packaging to their DHW. This includes any findings during their shift for medications already in place in the carts or during the narcotic count process.
Completion Date: Immediate and Ongoing
Responsible Party:
Community Medication Assistants- will report tampered packaging to DHW. They will follow 3 way new order check-in process.
DHW-is responsible in ensuring all processes are followed. DHW is responsible for performing routine medication cart audits. DHW will utilize the DL Medication Cart Audit Tool.

Licensee's Proposed Overall Completion Date: *01/11/2024*

Implemented [redacted] - 01/17/2024)

185a - Implement Storage Procedures

19. 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

On 9/25/2023, at 7:56 a.m., the glucometer for resident 7 reads 148; however, the MAR log reads 146.
On 9/24/2023, at 11:25 a.m., the glucometer for resident 7 reads 285; however, the MAR log reads 287.
On 9/23/2023, at 4:44 p.m., the glucometer for resident 7 reads 319; however, the MAR log reads 310.
On 9/23/2023, at 12:11 p.m., the glucometer for resident 7 reads 233; however, the MAR log reads 210.

Plan of Correction ***Accept ([redacted] 12/07/2023)***

Immediate Corrective Action:
CMA immediately retrained and educated on recording glucometer readings into the EMAR in an accurate manner following licensing survey. See attached documents.
1. Pennsylvania Medication Administration Program- Recertification/Certification- Mandatory and completed by all CMA's.
DHW responsible for ensuring compliance.
Date of Completion: 10.12.23
2. Penn State Beaver Diabetic/Insulin Training
Mandatory and completed by all CMA's.
DHW responsible for ensuring compliance.
Date of Completion: 9.18.2023

Long Term Quality Improvement Actions:
1. Routine medication administration checks with focus on ensuring the transcription of glucometer readings are

185a - Implement Storage Procedures (continued)

accurate.
DHW responsible for med passing all CMA's on a monthly basis. See attached document- Medication Administration Competency.
Date of Completion: New Hire and Monthly.
2. Routine follow up and review with Pharmacy Consultant.
Completion Date: 11.17.2023 with review every 6 months
3. Ongoing staff and routine CMA education and training led by DHW.
4. Additional Mandatory Training required for all CMA's employed at community:
• Pennsylvania Medication Administration Program- Recertification/Certification
Completion Date: Every 6 months
DHW responsible party
• Penn State Beaver Diabetic/Insulin Training
Completion Date: Annually
DHW responsible party

Licensee's Proposed Overall Completion Date: *01/31/2024*

Implemented [redacted] - 01/17/2024)

224a - Preadmission Screen Form

20. 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 3 was admitted to the home on [redacted]/2023; however, the resident's preadmission screening form was not completed.

Plan of Correction ***Accept ([redacted] - 11/29/2023)***

Prevention of Recurrence:
1. Personal Care Home Pre- admission Screening Form 2600 will be completed within 30 days prior to admission to community.

Responsible Parties:
ED
DSM
DHW

Method:
1. Community Clinical Admission Checklist is initiated for every new move-in.
2. DSM will reach out and schedule DHW for future resident assessments within 30 days of admission. Form 2600 will be completed at that time.
3. ED will ensure that the process is followed and maintained. Admissions will not be able to be moved forward

224a - Preadmission Screen Form (continued)

into the community unless the items on the Admission Checklist have been completed; including Form 2600.

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

227g -Support Plan Signatures

23. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident 3 participated in the development of [redacted] support plan on [redacted]/2023. However, the resident did not sign the support plan.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Corrective Actions:
Upon completion of Licensing Survey on 9.27.2023, all resident charts in Memory Support and Personal Care were audited to ensure that they all had a completed and signed support plan.
Responsible Party: DHW/Interim ED- implementing and signing support plans.
Completion Date: 9.30.23

Long Term Quality Improvement Actions:
1. DHW/ED will meet with resident/POA/Family within 15 days of admission to review Support Plan. Support Plan will be signed and dated at that time.
Responsible Party- ED and DHW
Date of Completion: Within 15 days of admission
2. ED/DHW will follow the Clinical Admission Checklist to ensure that the community is compliant.
Responsible Party- ED and DHW
Date of Completion: Within 15 days of admission

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

231c - Preadmission Screening

24. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] 2023. However, resident 3 does not have a written cognitive pre-admission screening.

231c - Preadmission Screening *(continued)*

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Corrective Actions:
Upon completion of Licensing Survey on 9.27.2023, all resident charts in Memory Support were audited to ensure that they all had a completed Cognitive Preadmission Screening Form.
Responsible Party: DHW and Medical Physician
Completion Date: 10.2.2023

Long Term Quality Improvement Actions:
1. Community Clinical Admission Checklist is initiated for every prospective new move-in.
Responsible Party: DSM
Completion Date: At community tour/deposit
2. DSM will work DHW to ensure that all new prospective admissions to memory support have a completed preadmission screening that includes the collaboration of a Physician or Geriatric Support Team within 72 hours prior to admission to a secured dementia care unit.
Responsible Party: DSM/DHW along with collaborating Physician or Geriatric Support Team
Completion Date: Within 72 hours prior to admission
3. ED will ensure that the process is followed and maintained. Admissions will not be able to be moved forward into the community unless the items on the Admission Checklist have been completed; including the Memory Support Preadmission Screening Tool.
Responsible Party: ED
Completion: Immediate and Ongoing

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

231e - No Objection Statement

25. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/2023. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept [redacted] - 12/07/2023)***

Immediate Actions:
1. Memory Care resident records were audited for presence of Memory Care Support Acknowledgement form for signatures. (Business Office completed 11/27/23)
2. Memory Care resident families and residents will be contacted to sign the Memory Support Acknowledgement form. (Business Office, ED- to be completed by 12/8/23)

Quality Improvement and Prevention of Recurrence:
1. The Memory Care Support Acknowledgement form will be completed at the time of the resident agreement signing and will be added to the resident record. (ED, Sales, Business Office- immediately and ongoing)

231e - No Objection Statement (continued)

2. The resident records will be audited for the presence of the Memory Support Acknowledgment form indicating residents/families do not object to memory care for each admission prior to the record being filed away. (ED, Business Office- immediately and ongoing)

Responsible Parties:

1. *Executive Director:*
2. *Business Office Director:*
3. *Other directors as assigned*

Licensee's Proposed Overall Completion Date: *12/31/2023*

Implemented [redacted] - 01/17/2024)

252 - Record Content

26. Requirements

2600.

252. Content of Resident Records - Each resident's record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.
5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

252 - Record Content *(continued)*

Description of Violation

Resident 3's record does not include eye color or hair color.

The Resident 7 record does not include eye color, hair color, or race of a photograph of the resident who is no more than 2 years old.

Plan of Correction ***Accept [redacted] - 11/29/2023)***

Prevention of Recurrence:

1. The Health & Wellness Director or assigned employee will enter all required information listed below into the community's EHR system for inclusion on the resident face sheet and/or medical record. (This information was previously not available in the home's EHR system.)

-Color of hair

-Color of eyes

-any identifying marks

2. A photo of every resident will be taken at time of move-in and included into the resident record.

Responsible Parties:

1. Health & Wellness Director:

2. Executive Director:

3. Other employees as assigned

Method:

1. Health & Wellness Director worked with home's EHR vendor to add all Pennsylvania required resident record information to the EHR database.

2. Health & Wellness Director will now be required to enter hair color, eye color to the resident EHR for inclusion in the resident record.

3. All resident records will be updated with Pennsylvania required resident record information in the EHR, by the Health & Wellness Director.

4. Audit of all current resident records completed by Health & Wellness Director to be completed by 12/1/23

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 01/17/2024)