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

November 21, 2023

[REDACTED], COO
IVQ LANSDALE OPCO LP
[REDACTED]

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/25/2023 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: *TRADITIONS OF LANSDALE* **Licen e #**: *14521* **Licen e Expiration**: *02/28/2024*

Address: *1800 WALNUT STREET, LANSDALE, PA 19446*

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

Administrator

Name **Phone**: **Email**:

Legal Entity

Name: *IVQ LANSDALE OPCO LP*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *Other* **Date**: *02/28/1986* **Issued By**: *Hatfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *115* **Waking Staff**: *86*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *10/20/2023*

Inspection Dates and Department Representative

09/25/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *150* **Re ident Served**: *87*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *71* **Re ident Served**: *20*

Hospice

Current Re ident : *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *87*

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

Have Mobility Need: *28* **Have Physical Disability**: *0*

Inspections / Reviews

09/25/2023 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/03/2023*

Inspections / Reviews *(continued)*

11/13/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/16/2023*

11/21/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/15/2023*

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

81a - Accomodation

1. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Description of Violation

Resident 1 does not have handicap accessible accommodations for their Wheelchair in their bathroom.

Plan of Correction ***Accept - 11/13/2023)***

81.a:
The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

Evidence:
1. Resident 1 does not have handicap accessible accommodations for their Wheelchair in their bathroom.
POC:
Immediate corrective actions: Resident will use the handicap bathroom provided within the community for both showers and using the restroom as needed.
Additional corrective actions: RASP has also been updated to reflect the utilization of the community shower room/bathroom.
Ongoing actions: Resident 1 will have the option to move into another apartment with a larger shared bathroom as one becomes available. Conversation with family will take place as apartments become available to see if family would like to make a move.

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

Implemented (- 11/21/2023)

183f - Discontinued Medications

2. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The following medication belonging to resident 2 was discontinued on . However the medication remained in the home. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

The following medication belonging to resident 2 was discontinued on . However the medication remained in the home. This is not an approved method of destroying medications according to the Department of Environmental Protection and Federal and State regulation.

183f - Discontinued Medications (continued)

Plan of Correction ***Accept (11/13/2023)***

183.f:
Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no onger served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Evidence:
1. belonging to resident 2 was discontinued on . However, the medication remained in the home.
2. belonging to resident 2 was discontinued on However the medication remained in the home.
POC:
mmediate corrective actions:
Assistant Executive Director has been removed from the nursing department and no longer oversees medications or nursing staff.
Resident #2 is no longer in the community and all medications were immediately removed from the cart and destroyed per policy.
Additional corrective actions: Cart audits were completed on 10/30 and 10/31. Any expired medications have been removed from the med carts and destroyed per policy.
Additional Training on 5 Rights of Medication Management and Medication Destruction and Storage Procedures will also take place by Executive Director beginning 11/1 and will be completed by 11/15.
Ongoing actions: Routine med cart audit spot checks will be conducted at least one time per month by the Executive Director, Resident Care Director, or Memory Care Director going forward. RCD and MCD will review Med Tech Cart Audits and spot checks during weekly nursing meetings. Audits will also be reviewed at the Quarterly QA Meetings, beginning with the 2023 Q4 Review, to be held in January 2024.

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

Implemented - 11/21/2023)

185a - Implement Storage Procedures

3. Requirements

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

Description of Violation

Resident 1 is prescribed as needed. On 9/25/2023 the medication was not available in the home.

185a - Implement Storage Procedures *(continued)*

Plan of Correction ***Accept (MJ - 11/13/2023)***

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.

Evidence:
1. Resident 1 is prescribed [redacted] as needed. On 9/25/2023 the medication was not available in the home.
POC:
mmediate corrective actions: LPN called physician to identify where the mediation needs to be refilled or DC'd.
Additional corrective actions: Cart audits were completed on 10/30 and 10/31 and all of the medications for this resident are accounted for.
Training for the following will take place for Med Techs and nurses: 5 Rights of Medication Management and Medication Destruction and Storage Procedures will also take place by Executive Director beginning 11/1 and will be completed by 11/15.
Ongoing actions: Routine med cart audit spot checks will be conducted by the Executive Director, Resident Care Director, and Memory Care Director going forward. RCD and MCD will review Med Tech Cart Audits and spot checks during weekly nursing meetings. Audits will also be reviewed at the Quarterly QA Meetings, beginning with the 2023 Q4 Review, to be held in January 2024.

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

Implemented [redacted] - 11/21/2023)

185b - Medication Procedures

4. Requirements

2600.
185.b. At a minimum, the procedures must include:

1. Documentation of the receipt of controlled substances and prescription medications.
2. A process to investigate and account for missing medications and medication errors.
3. Limited access to medication storage areas.
4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

Staff Person A is not following the procedure to have 2 staff members present during destroying narcotics.

There were 4 syringes of [redacted] belonging to resident 2 missing from the medication cart that were not documented as being administered to the resident.

185b - Medication Procedures *(continued)*

Plan of Correction ***Accept (- 11/13/2023)***

185.b:
At a minimum, the procedures must include: 1. Documentation of the receipt of controlled substances and prescription medications. 2. A process to investigate and account for missing medications and medication errors. 3. Limited access to medication storage areas. 4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.
Evidence:
1. Staff Person A is not following the procedure to have 2 staff members present during destroying narcotics.
2. There were 4 syringes of belonging to resident 2 missing from the medication cart that were not documented as being administered to the resident.
POC:
mmediate corrective actions: Staff #A was removed from responsibility as the Assistant Executive Director overseeing all aspects of the Resident Care Department.
Executive Director has now assumed all aspect of the Wellness department during the interim.
Resident #2 is no longer in the community and all medications were immediately removed from the cart and destroyed per policy.
Additional corrective actions: All med techs were in-serviced by the Executive Director on the policy to destroy narcotics. Training will begin on 11/1 and will be completed by 11/15. Training to include medication storage and destruction and narcotic shift count. Executive Director and LPN routinely observe shift to shift narcotic count.
Ongoing actions: Random audits of the narcotic logs as well as random interviews of Med Techs to verify medications/narcotics are disposed of per policy at least one time per month. Audits will be conducted by the Executive Director, Resident Care Director, or Memory Care Director. This will be reviews at the quarterly QA beginning Q4 of 2023 which will take place in January of 2024.

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

Implemented - 11/21/2023)

224a - Preadmission Screen Form

5. 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 however, the resident's preadmission screening form was completed on

Plan of Correction ***Accept (11/13/2023)***

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.
Evidence:
1. Resident 3 was admitted to the home on ; however, the resident's preadmission screening form was

224a - Preadmission Screen Form (continued)

completed on [redacted]
POC:
mmediate Corrective Actions- This violation could not be corrected immediately. ED will review new admission process to ensure nursing team completes Prescreen Prior to new admission.
Additional Corrective Actions- The Executive Director will review all new admissions for timely completely for all pre-admission screens. The Executive Director will in-service all nurse and marketing team to ensure a Pre-Admission Screening is completed prior to offering admission to a potential new resident.
Ongoing Corrective- The Executive Director will conduct a 30 day chart audit and audits will reviewed at the quarterly QA beginning Q4 of 2023 which will take place in January of 2024.

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

Implemented ([redacted] 11/21/2023)

251b - Record Entries Legible

6. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Resident 2's Narcotic Count sheet for Medication [redacted] had multiple lines of scribbled out names making the sheet illegible.

Plan of Correction ***Accept [redacted] - 11/13/2023)***

251.b:
The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.
Evidence:
1. Resident 2's Narcotic Count sheet for Medication [redacted] had multiple lines of scribbled out names making the sheet illegible.
POC:
mmediate corrective actions: Staff #A was removed from responsibility as the Assistant Executive Director overseeing all aspects of the Resident Care Department.
Executive Director has now assumed all aspect of the Wellness department during the interim.
Resident #2 passed away and is no longer in the community and all medications were immediately removed from the cart and destroyed per policy.
Additional corrective actions: All med techs were in-serviced by the Executive Director on the policy to destroy narcotics. Training will begin on 11/1 and will be completed by 11/15. Training to include medication storage and destruction and narcotic shift count. Executive Director and LPN routinely observe shift to shift narcotic count.
Ongoing actions: Random audits of the narcotic logs as well as random interviews of Med Techs to verify medications/narcotics are disposed of per policy. Audits will be conducted by the Executive Director, Resident Care Director, or Memory Care Director. This will be reviews at the quarterly QA beginning Q4 of 2023 which will take place in January of 2024.

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

Implemented ([redacted] - 11/21/2023)