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

February 20, 2024

[redacted]
600 PAOLI POINTE DRIVE OPERATIONS LLC
[redacted]

RE: HIGHGATE AT PAOLI POINTE
600 PAOLI POINTE DRIVE
PAOLI, PA, 19301
LICENSE/COC#: 13610

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/27/2023 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: *HIGHGATE AT PAOLI POINTE* **License #**: *13610* **License Expiration**: *10/02/2024*

Address: *600 PAOLI POINTE DRIVE, PAOLI, PA 19301*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *600 PAOLI POINTE DRIVE OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/15/1966* **Issued By**: *Department of L & I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *82* **Waking Staff**: *62*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *11/27/2023*

Inspection Dates and Department Representative

11/27/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *124* **Residents Served**: *46*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory care* **Capacity**: *30* **Residents Served**: *16*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

11/27/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/29/2023*

01/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/08/2024*

Inspections / Reviews *(continued)*

01/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/15/2024*

02/20/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2024*

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], it was not notated on resident [redacted] medication record if the resident had received [redacted] drops in each [redacted], or reason for it not being received. The home did not report this medication error to the Department.

Plan of Correction ***Accept [redacted] - 01/03/2024)***

Agency employee that omitted medication documentation has not returned to work at the community since the omission occurred. Agency staff will be required to complete education and medication administration competency prior to returning to work inside the community.
Audit completed on [redacted] of December's MARS for any additional omissions. No deficient practice found.
Nurses and Medication Techs will be re-educated on immediate notification to the Director of Health and Wellness (DHW) of any Omissions in the MAR by 1.15.2024
DHW was re-educated on 12/26/2023 of the requirement to report the Medication error to the DHW regional Office within 24 hours of her notification.

R/P: Executive Director and DHW/Designee

Proposed Overall Completion Date: 01/15/2024

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented [redacted] 02/20/2024)

16d - Final Incident Report

2. Requirements

2600.
16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On [redacted], the home submitted an initial and final incident report of financial exploitation of resident [redacted] by staff member A which was discovered [redacted]. The home did not complete, document, or keep a record of an internal investigation of this incident, nor submit it to the Department. The home stated the staff member was an agency employee and the police detective involved collected information pertaining to the incident.

Plan of Correction ***Accept [redacted] - 01/03/2024)***

Employee was a contract. Contracting company notified on [redacted] that the employee was not to return to the community. The Executive Director (ED) and DHW was educated on [redacted] of the process of completing an internal investigation.
Audit completed of Reportable Incidents that have occurred since October. No other deficient practices noted for failure to report Financial exploitation. ED completed this audit on 12/29/2023.
Community Staff re-educated on reporting any potential financial exploitation of a resident by 1.15.2024
ED will collaborate with Genesis Senior Living Market President or Market Clinical Lead on internal financial

16d - Final Incident Report (continued)

investigation as needed for the next three months or until compliance is determined. Findings will be reported to QAPI.

R/P Executive Director/Designee

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented [redacted] 02/20/2024)

16e - Resident Notice

3. Requirements

2600.
16.e. If the home's final report validates the occurrence of the alleged incident or condition, the affected resident and other residents who could potentially be harmed or his designated person shall also be informed immediately following the conclusion of the investigation.

Description of Violation

On [redacted], the home submitted a final incident report validating the occurrence of financial exploitation by staff member A to resident [redacted] As of [redacted], the home has not informed other residents that may have been affected or their designated persons. Staff member A had access to all rooms in the building except on the 3rd floor.

Plan of Correction ***Accept [redacted] - 01/03/2024)***

ED was re-educated on 12/20/2023 of the requirement to notify residents/ POAs of financial exploitation by a contracted staff member.

Letters sent on 12/20/2023 to current residents and / or POA informing them of the financial exploitation of another resident and requested they notify the ED of any concerns.

ED will collaborate with Genesis Senior Living Market President or Market Clinical Lead on notification of residents/POAs for Financial exploitation as needed for the next three months or until compliance is determined. Findings will be reported to QAPI.
***Please see family letter attached*
RP-Executive Director/Designee

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented [redacted] - 02/07/2024)

42b - Abuse

4. 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], it was discovered that resident [redacted] was financially exploited by staff member A. The power of attorney of resident [redacted] reported staff member A had cashed a [redacted] check written to [redacted] name from the resident's bank account. The account is only used to pay resident's fees to the home. Staff member A was employed through an agency. [redacted] checks were missing from a checkbook the resident had hidden in a bedside table. POA was not aware resident was in possession of the checkbook. The bank refunded the resident's money and stopped the missing

42b - Abuse (continued)

checks, however the POA had decided to allow the account to remain active. Staff member A attempted unsuccessfully to cash another check for [redacted] but was stopped by the bank. Resident [redacted] denied writing the check, and POA stated the signature was forged. When staff member A was interview by the detective involved in the case, [redacted] stated the resident had given them the checks as a tip. The home has a system to safeguard money and property and offers a common safe, but does not provide individual lock boxes to the residents. The letter informing the residents of this system was not present in Resident [redacted] contract or file.

On [redacted] at [redacted], staff member B, who is an agency staff person, was working in the Secure Dementia Care Unit. While attempting to change resident [redacted] [redacted] product, resident [redacted] became agitated, and staff member B roughly pulled the resident off [redacted] bed and onto the floor by [redacted] arm and changed the resident on the floor while the resident was partially siting with their back against the bed. Staff member C entered, and both staff members pulled the resident to [redacted] feet and lay [redacted] on the bed, leaving them undressed and uncovered.

Plan of Correction ***Accept [redacted] - 01/10/2024)***

Residents [redacted] Checks secured on [redacted] by Management and given to the resident's niece to take home with [redacted]. System to Safeguard a Resident's Money and Property form was updated on [redacted] The updated form was also mailed to residents responsible parties.

[redacted] BOM completed an audit on [redacted] of current residents for contract files to make sure that each resident has the System to Safeguard a Resident's Money and Property signed and in their contract file. The System to Safeguard a Resident's Money and Property signed Resident files that had the same deficient practice corrected [redacted]

The new contract packets validated on [redacted] that they have the form in them and will be signed when the contract is signed prior to admission.

ED/Designee will audit the new admission agreement for System SafeGuard, a Resident Money Property form signed on admission for three months or until compliance is determined. Findings will be reported in QAPI.

Agency of Staff Member B was notified on [redacted] that the employee was not to return to the community.

Community Staff educated by 1.15.2024 on appropriate handling and communication of residents with dementia during personal care.

DHW /Designee will monitor personal Care in the dementia care neighborhood weekly for three months or until compliance is determined. Findings will be reported in QAPI.

R/P Director of Health and Wellness

Licensee's Proposed Overall Completion Date: *01/05/2024*

Implemented [redacted] - 02/20/2024)

62 - Contact List

5. Requirements

2600.

62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

62 - Contact List *(continued)*

Description of Violation

The home could not provide a current list of all staff including agency staff.

Plan of Correction ***Accept [redacted] - 01/10/2024)***

Community created a current staff, contract and agency employee list as of [redacted] [redacted] BOM re-educated on [redacted] and the requirement to maintain a current persons that work, agency, contract or volunteer for the community. Contact list updated on 1/5/2023.
[redacted] ED will audit weekly times three months or until compliance is determined for appropriate list persons that work, agency, contract or volunteer for the community. Findings will be reported to QAPI

R/P BOM and Director of Health and Wellness

Licensee's Proposed Overall Completion Date: *01/05/2024*

Implemented [redacted] - 02/07/2024)

65a - FS Orientation 1st Day

6. 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 member 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.

Plan of Correction ***Accept [redacted] - 01/03/2024)***

The Contracted Company was notified on [redacted] that their employee A was not to return to the community.
New employees as of [redacted] files audited to validate required orientation were documented in their personnel files. No other deficient practices noted.
Business Office Manager (BOM) was educated on [redacted] by the ED on required new hire contact employee orientation.
ED/Designee will audit new hire employees orientation education every week for the next three months or until compliance is determined. Findings will be reported to QAPI
Executive Director educated BOM on this process for 2600.65a, on [redacted]. BOM will make sure that all staff including HCSG and agency staff have this education upon starting their first shift in this community. Executive

65a - FS Orientation 1st Day (continued)

director will audit for the next 3 months to verify this is being completed.

R/P BOM and Executive Director/Designee.

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented [redacted] - 02/20/2024)

65b - Rights/Abuse 40 Hours

7. 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 member A completed [redacted] 40th scheduled work hour on [redacted]. However, this staff member did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions.

Plan of Correction ***Accept[redacted] 01/03/2024)***

The Contracted Company was notified on [redacted] that their employee A was not to return to the community.
New employees as of [redacted] files audited to validate required orientation were documented in their personnel files. No other deficient practices noted.
Business Office Manager (BOM) was educated on [redacted] by the ED on required new hire contact employee orientation.
ED/Designee will audit new hire employees orientation education every week for the next three months or until compliance is determined. Findings will be reported to QAPI
Executive Director educated BOM on this process for 2600.65a, on [redacted]. BOM will make sure that all staff including HCSG and agency staff have this education upon starting their first shift in this community. Executive director will audit for the next 3 months to verify this is being completed.

R/P BOM and Executive Director/Designee

Licensee's Proposed Overall Completion Date: *01/15/2024*

Implemented [redacted] - 02/20/2024)

85a - Sanitary Conditions

8. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On [redacted], at approximately [redacted], the back of the hallway in the Terrace area, which contained two fabric

85a - Sanitary Conditions (continued)

chairs, had a pungent odor of urine. The smell did not appear to be originating from any room in the area.

Plan of Correction ***Accept - 01/10/2024)***

Chairs on the back hall of the Terrace area were removed and cleaned on . Executive Director and Housekeeping Director completed the audit on ..
Audit was conducted on and will start weekly audits on 1/conducted weekly for furniture that had a urine odor. No other deficient practice noted.
Staff will be educated by the notification of housekeeping and ED of any furniture that has an odor for cleaning.
Executive Director and Housekeeping Director completed the audit on .
ED/designee will conduct weekly walking rounds for furniture with a urine odor for the next three months or until compliance is determined. Findings will be reported to QAPI

R/P Housekeeping Director and Executive Director/Designee

Proposed Overall Completion Date: 01/05/2024

Licensee's Proposed Overall Completion Date: *01/05/2024*

Implemented 02/07/2024)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident is prescribed , drop in each at bedtime. This medication was not administered on

Resident is prescribed , and . However, these medications were not administered to resident on because the medications were not available in the home.

Plan of Correction ***Accept - 01/10/2024)***

Audit completed on of December's MARS for any additional omission and unavailable medications found.
Resident Care Director completed the
S completed the audit on
Nurses and Medication Techs re-educated on immediate notification to the Director of Health and Wellness (DHW) of anavry Omissions in the MAR and Unavailable Medication by 1.15.2023.
Nurses and medication techs with omissions going forward as of 1.15.2023 will have immediate written corrective action and medication pass observation prior to next medication administration pass.
DHW/Designee will audit for omissions and unavailable medication weekly for three months or until compliance is determined. Findings will be reported in QAPI.

R/P Director of Health and Wellness/Designee

Proposed Overall Completion Date: 01/05/2024

Licensee's Proposed Overall Completion Date: *01/05/2024*

187d - Follow Prescriber's Orders *(continued)*

Implemented [redacted] 02/20/2024)