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

November 29, 2023

[redacted], REGIONAL DIRECTOR OF OPERATIONS
NORTH WALES 1091 PCH BG OPCO LLC
[redacted]

RE: PARK CREEK PLACE - PERSONAL CARE
1091 HORSHAM ROAD
NORTH WALES, PA, 19454
LICENSE/COC#: 14257

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/19/2023, 10/20/2023, 10/27/2023 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: *PARK CREEK PLACE - PERSONAL CARE* **License #**: *14257* **License Expiration**: *01/30/2024*

Address: *1091 HORSHAM ROAD, NORTH WALES, PA 19454*

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

Administrator

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

Legal Entity

Name: *NORTH WALES 1091 PCH BG OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/28/1999* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *10/19/2023*

Inspection Dates and Department Representative

10/19/2023 - On-Site: [redacted]
10/20/2023 - Off-Site: [redacted]
10/27/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *72* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *12* **Have Physical Disability**: *1*

Inspections / Reviews

10/19/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/13/2023*

Inspections / Reviews *(continued)*

11/20/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/28/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/24/2023*

11/29/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/28/2023*

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

23a - Activities of Daily Living Assistance

1. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Residents 1, 2, and 3 are not receiving care for toileting, bowel movements, and transferring in a timely manner as required by their support plans. Call bells are pressed and staff are not responding for over an hour.

Plan of Correction ***Accept [redacted] - 11/20/2023)***

In response to this violation, the Executive Director and Director of Maintenance checked the community's pendant system pc for proper operation and all pagers had batteries replaced on 10/20/2023. The Health and Wellness Director, Assistant Nurse and Executive Director were all supplied with pagers that have a timed escalation feature on 10/25/2023. (Image A)

• Executive Director completed a personal pendant audit to verify all residents have working pendants on 11/1/2023. (Document A1)

• All current residents were surveyed by the Executive Director or designee to ascertain their sense of safety in receiving appropriate and timely care from care staff at community by 11/9/23. (Document A2)

• Health and Wellness Director will provide training to all current staff on regulation 2600.23a and community pendant policy by 11/17/23. (Document A3)

• Executive Director and/or designee will review previous day's pendant call reports by the following business day during morning Stand-up Meeting to verify that all residents are receiving responses for calls for care in a timely manner from November 6, 2023 through January 31, 2024. (Document A4)

• A2-Executive Director or designee will review audit results at monthly QA meeting from November 2023 through January 2024. The QA Committee will direct and record further interventions as required to maintain/sustain compliance. (Document A5)

• Completion Date 1/31/24

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

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

Implemented ([redacted] - 11/29/2023)

42b - Abuse

2. 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

Resident 1 had a fall on [redacted] while being transferred to his/her lift. The resident rolled off the bed thinking a staff

42b - Abuse (continued)

person was present on that side and there was not. Resident 1 is also an immobile full assist resident who requires care for toileting, transferring, bowel movements, and needs full assistance for care which they are not receiving in a timely manner. On [redacted], the call bell log shows a time of 1:30:52 to respond.

Resident 2 fell off of his/her lift. The resident stated there was only one staff person was present. The resident is a two person assist. They also stated have to wait long time for bowel movement/bladder care. Based on call bell logs from [redacted] the elapsed time to room was 1:02:56

Resident 3 uses a wheelchair and a Hoyer lift for transfers. The home's staff are not answering his/her call bells timely. They wait well over an hour for responses to their bells and it's a continuous problem for this resident. They need full assistance to toilet, transfer, be changed, and cleaned. The home is not providing this care to the resident timely. On [redacted] call bell logs show an elapsed time to room as 1:04:51.

Resident 4 had a fungal rash under their [redacted] that staff were refusing to care for because of its location. Staff were not applying the medication to his/her rash. The rash began to get worse and caused an odor that caused the resident to feel embarrassed and they would not leave their room. They also shared they have waited for 20 minutes for call bell when they had difficulty breathing. On [redacted] the call bell log shows an elapsed time to room of 22:18.

Plan of Correction ***Accept ([redacted] - 11/20/2023)***

In response to this violation, all current residents were interviewed by the Executive Director or designee to ascertain their sense of safety in receiving appropriate and timely care from all staff at community by 11/9/23. (Document B1)
**Health and Wellness Director will in-service current care staff on regulation 2600.42b as well as community Skin and Wound Care policy by 11/17/2023. (Document B3)*
• FOX Rehabilitation Physical Therapist completed Hoyer training for care staff on 10/23/2023 and 10/25/2023. (Document B4/B4(2))
• Executive Director or designee will survey all of the residents identified in both this report and audits, weekly from 11/6/2023 to 1/31/2024, to determine any perceived lapses of care to address. (Document B5)
• Executive Director or designee will review audit results at monthly QA meeting from November 2023 through January 2024. The Committee will direct and record further interventions as required to maintain/sustain compliance. (Document B6)
• Completion Date 1/31/2024

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

Implemented ([redacted] - 11/29/2023)

42c - Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Resident 4 had a fungal rash under their [redacted] that staff were refusing to care for because of its location. Staff were not applying the medication to his or her rash. The rash began to get worse and caused an odor that caused the resident to feel embarrassed and they would not leave their room. They also shared they have waited for 20 minutes for call bell when they had difficulty breathing

Plan of Correction ***Accept ([redacted] - 11/20/2023)***

•In response to this violation, resident 4 was re-checked on 10/23/2023 and it was identified that the rash had completely cleared up a month ago and resident's PCP discontinued the cream on 11/7/2023. (Doc C1)
• Health and Wellness Director will in-service community staff on regulation 2600.42c and community policy on Change in Condition reporting by 11/17/23. (Document C3)
• Executive Director or designee will survey all of the residents identified in both this report and audits, weekly from 11/6/2023 to 1/31/2024, to determine any perceived lapses of care to address. (Document B5)
• A2- Executive Director or designee will review audit results at monthly QA meeting from November 2023 through January 2024. The Committee will direct and report further interventions as required to maintain/sustain compliance. (Document C5)
• Completion Date 1/31/24

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

Implemented [redacted] - 11/29/2023)

60a - Staff/Support Plan

4. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home does not have adequate staff to cover the needs of residents 1, 2, and 3, as indicated in their support plans. These residents require two person assistance with Hoyer lifts. The homes direct care staff are tasked with serving meals and providing care.

60a Staff/Support Plan *(continued)*

Plan of Correction ***Accept ([redacted] - 11/20/2023)***

• In response to this violation two additional FT caregivers were hired on 10/25/2023 11/09/2023. (Document D1)
• Health and Wellness Director to in service care scheduling staff on regulation 2600.60a by 11/17/2023. (Document D3)
• Director or designee will audit care staff schedules and care level changes weekly from November 6, 2023 through January 31, 2024 to verify that the community is staffed to meet the needs of the residents. (Document D4)
• Executive Director and/or designee will audit care plan changes weekly to determine if any changes impact the number of staffing hours needed to adequately care for the residents' needs. (Document D5)
• Executive Director or designee will review audit results at monthly QA meeting from November 2023 until January 2024. The Committee will direct and record further interventions as required to maintain/sustain compliance. (Document D6)
• Completion Date 1/31/2024

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

Implemented ([redacted] - 11/29/2023)

101j7 - Lighting/Operable Lamp

5. 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

Resident 1 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 11/20/2023)***

•In response to this violation a lamp was placed on the resident's bedside table by the Director of Maintenance on 10/27/2023. (Document E1)
• Health and Wellness Director or designee will provide training to all staff on regulation 101j7 by 11/17/2023. (Document E3)
• Executive Director or designee completed an audit of current resident apartments to verify that there is a working lamp at the bedside compliance with 2600 101j7 on 10/27/23. (Document E4)
• Executive Director and/or designee will conduct an audit of current resident's apt. monthly from November 6, 2023 to January 31, 2024 to verify that current resident's lamps are in working order and have not been moved from the bedside . (Document E5)
• Executive Director or designee will review audit results at monthly QA meeting from November 2023 until January 2024. The Committee will direct further and report any interventions as required to maintain/sustain compliance. (Document E6)

101j7 - Lighting/Operable Lamp (continued)

• Completion Date 1/31/24

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

Implemented ([redacted] - 11/29/2023)

252 - Record Content

6. 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 hair or eye color.
Resident 4's record does not include hair or eye color.
Resident 5's record does not include hair or eye color.
Resident 6's record does not include hair or eye color.

Plan of Correction ***Accept ([redacted] - 11/20/2023)***

• In response to this violation the Executive Director and designee updated the records of resident 3, 4, 5 and 6 to include hair color and eye color on 11/6/2023. (Document F1)
• Executive Director will in service appropriate administrative staff on regulation 252 by 11/17/2023. (Document F3)
• Executive Director or designee will audit all current residents' files to determine whether their records are compliant with regulation 2600.252 (Document F4)
• Executive Director or designee will review the record of any new resident upon move in day to verify that their resident file is compliant with 2600.252 (Document F5)
• Executive Director or designee will review audit results at monthly QA meeting from November 2023 through January 2024. The Committee will direct further and report any interventions as required to maintain/sustain compliance. (Document F6)
• Completion Date 1/31/24

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Proposed Overall Completion Date: 01/31/2024

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

Implemented ([redacted] - 11/29/2023)