

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

April 25, 2023

[REDACTED], REGIONAL DIRECTOR OF OPERATIONS
CA SENIOR VALLEY FORGE OPERATOR LLC
[REDACTED]

RE: ANTHOLOGY OF KING OF PRUSSIA
350 GUTHRIE ROAD
KING OF PRUSSIA, PA, 19406
LICENSE/COC#: 14788

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/24/2023 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: ANTHOLOGY OF KING OF PRUSSIA **License #:** 14788 **License Expiration:** 03/23/2024
Address: 350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406
County: MONTGOMERY **Region:** SOUTHEAST

Administrator

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

Legal Entity

Name: CA SENIOR VALLEY FORGE OPERATOR LLC
Address: [REDACTED]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-1	Date: 12/08/2020	Issued By: Upper Merion Township
Type: I-2	Date: 12/08/2020	Issued By: Upper Merion Township
Type: Other	Date: 12/08/2020	Issued By: Upper Merion Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 73 **Waking Staff:** 55

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 01/24/2023

Inspection Dates and Department Representative

01/24/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 128 **Residents Served:** 47

Secured Dementia Care Unit

In Home: Yes **Area:** Virtue **Capacity:** 28 **Residents Served:** 20

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 47
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 26	Have Physical Disability: 0

Inspections / Reviews

01/24/2023 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 02/12/2023

Inspections / Reviews (*continued*)

02/14/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/09/2023

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 02/12/2023

02/16/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/07/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/31/2023

04/25/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/07/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [REDACTED], began providing unsupervised ADL services on [REDACTED]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept [REDACTED] - 02/14/2023)

This violation was previous identified and was accepted on a POC already in place. Community had already completed an audit based off of POC from the 12/13/2022 visit. We ask that this violation be withdrawn due to self identifying team members that are not in compliance. As of 2/7/2023, all staff has obtained their direct care certificate. Proof of completion is available upon request.

In the future all direct care staff that can not provide documentation of certification hire, will be schedule to take the department approved direct care training course and pass the competency test prior to starting on the floor. The Executive Director and or Business office manager will review all paperwork prior to day two of orientation to ensure new staff is compliant. The will be done ongoing moving forward.

Licensee's Proposed Overall Completion Date: 02/08/2023

Implemented [REDACTED] 04/25/2023)

141b1 - Annual Medical Evaluation

2. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on 4/14/21.

Plan of Correction

Accept [REDACTED] - 02/14/2023)

Resident #1 next medical evaluation will be completed by [REDACTED] to ensure date compliance. The Director of Health and Wellness will be responsible for making sure all move ins have a DME completed within 60 day prior or 30 days after move in for all personal care residents and no more then 30 days prior for all memory care residents.

An audit of DME's was completed by the Regional Nurse on 1/27/2023. A tickler of up coming due dates has been developed by the regional nurse and put in place by the Director of Health and Wellness on 1/30/2023. All DME that were found to be out of date compliance will be completed by 2/17/2023.

Documentation will be made on the DME to show that the community, self identified the occurrence and that a new DME was obtained to ensure compliance moving forward. An audit will be completed monthly by the Executive Director or Assistant Executive Director to verify dates and accuracy. These audits will continue through 8/31/2023.

Licensee's Proposed Overall Completion Date: 02/17/2023

141b1 Annual Medical Evaluation (continued)

Implemented [REDACTED] - 04/25/2023)

187d Follow Prescriber's Orders

3. Requirements

2600.

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

Description of Violation

Resident #2 is prescribed [REDACTED] twice daily. However, this medication was not administered to the resident on [REDACTED] at [REDACTED] because the medication was not available in the home.

Repeated Violation: 3/30/22, 5/18/22, 6/3/22, 8/24/22

Plan of Correction

Accept [REDACTED] - 02/16/2023)

Meeting was held by the Director of Health and Wellness and the Executive Director with the preferred pharmacy on 2/14/2023 to discuss/develop a strategic plan for identifying when medication need refill orders and pharmacy follow up when a medication is running low. This will help in preventing medications being unavailable in the future.

All Med Techs will be retrained in following all prescribers orders by 2/24/2023. This will allow for the strategic plan that is developed with the pharmacy to be shared with the med techs. This training will be done by the Director of Health and Wellness in conjunction with the Executive Director. Director of Health and Wellness will run the missed medication report 5 days a week starting 2/10/2023. This will continue through 6/1/2023.

Any medication that is missed or improperly given, will be reported to the physician, the family by the Dayshift nurse, and DHS as a medication error by the Director of Health and Wellness or Executive Director. Disciplinary action will occur for Med Techs who continue to not follow policy and procedure. This disciplinary action will be given by the Director of Health and Wellness, Assistant Executive Director, or Executive Director.

Licensee's Proposed Overall Completion Date: 02/24/2023

Implemented [REDACTED] - 04/25/2023)

225a Assessment 15 Days

4. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An assessment was not completed for Resident #1, who was admitted to the home on [REDACTED]

Plan of Correction

Accept [REDACTED] - 02/14/2023)

This was previously self identified based off of the audit conducted on 10/19/2022. RASP was completed [REDACTED], this was actually the initial since one was not done on move in. Any RASP that was found out of compliance during the 10/19/2022 audit has been noted to be self identified and corrected moving forward. This was completed 11/18/2022 by the Director of Health and Wellness.

225a Assessment 15 Days (continued)

A tickler of up coming due dates has been developed by the regional nurse and put in place by the Director of Health and Wellness on October 30, 2022. Moving forward all assessments will be done initially and annually thereafter or significant change.

The Director of Health and Wellness or Director of Virtue will audit assessment monthly starting 2/1/2023 and continue through 8/31/2023.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 04/25/2023)