pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **CA SENIOR VALLEY FORGE OPERATOR LLC**
LEGAL ENTITY

To operate **ANTHOLOGY OF KING OF PRUSSIA**
NAME OF FACILITY OR AGENCY

Located at **350 GUTHRIE ROAD, KING OF PRUSSIA, PA 19406**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **128**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 28**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **January 16, 2024** until **January 16, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **147880**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: January 16, 2024

[redacted]

RE: Anthology of King of Prussia
350 Guthrie Road
King of Prussia, Pennsylvania 19406
License #: 147880

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on July 6 and 7, 2023 and December 11, 2023, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

January 12, 2024

[redacted]
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 07/06/2023, 07/07/2023 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**: *08/10/2023*

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]

Email *k*[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**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal, Provisional* **Exit Conference Date**: *07/07/2023*

Inspection Dates and Department Representative

07/06/2023 - On-Site: [redacted]

07/07/2023 - 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**: *22*

Hospice

Current Residents: *3*

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: *24* **Have Physical Disability**: *0*

Inspections / Reviews

07/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/05/2023*

Inspections / Reviews *(continued)*

08/08/2023 - POC Submission

Submitted [redacted] **Date Submitted**: *08/04/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/13/2023*

08/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/13/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/21/2023*

01/08/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/24/2023*

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

42s - Privacy

1. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

There are no signs indicating video surveillance by the front door of the home.

Plan of Correction ***Accept (- 08/08/2023)***

Corrected immediately at the time of inspection. ED will inspect all public entrances monthly to ensure video surveillance signs are posted.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented - 11/07/2023)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/20/23 and 7/1/23, from 11 pm to 7 am, 47 residents were present in the home. During this time no staff person certified in First Aid or CPR was present in the home.

Repeat Violation: 12/13/22.

Plan of Correction ***Accept (- 08/08/2023)***

Director of Health and Wellness (HWD)/Business Office Director (BOD) or designee to review schedule weekly to ensure at least one CPR certified staff person per 50 residents is scheduled at all times as per requirement. HWD will schedule CPR class quarterly or as needed to ensure community meets the requirement ongoing. CPR classes scheduled various dates in August of 2023. HWD or designee to review schedule weekly to determine additional needs and modify nursing schedule as needed to ensure requirement is met.

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

Implemented (- 11/07/2023)

65e - 12 Hours Annual Training

3. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A received zero hours of annual training in the training year 2022.

Plan of Correction ***Accept - 08/17/2023)***

Staff person A completed all required annual training by 7-13-23 via Relias and in person instruction and is

65e - 12 Hours Annual Training (continued)

currently in compliance. BOD or designee will audit relias transcripts every 2 weeks to ensure all employees annual training requirements are current for 90 days. ED or designee to audit all employee training records monthly ensure continued compliance. All training records will also be reviewed by Business Office Director and Executive Director quarterly at QAPI meetings.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 11/07/2023)

65f - Training Topics

4. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in the following topics during the training year 2022.

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Plan of Correction ***Accept [redacted] - 08/17/2023)***

Staff person A completed all required training topic, 1-7, with completion date of 7-13-23, and is currently in compliance. Staff person A will be regularly scheduled to complete required annual topics to ensure ongoing compliance by BOD. BOD or designee will audit relias transcripts every 2 weeks to ensure all employees annual training requirements are current for 90 days. ED or designee to audit all employee training records monthly to ensure continued compliance ongoing. All training records will also be reviewed by Business Office Director and Executive Director quarterly at QAPI meetings.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 11/07/2023)

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in the following areas during the training year 2022.

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

3. Resident rights.

4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

5. Falls and accident prevention.

6. New population groups that are being served at the home that were not previously served, if applicable.

Plan of Correction ***Accept (MJ - 08/17/2023)***

Staff person A completed all 6 requirements on or before 7-15-23 via Relias and in person instruction and is currently in compliance. Business Office Director or designee will audit relias transcripts every 2 weeks to ensure all employees annual training requirements are current for 90 days. ED or designee will audit all employee training records monthly to ensure continued compliance. All training records will also be reviewed by Business Office Director and Executive Director quarterly at QAPI meetings.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 11/07/2023)

66b - Training Plan Content

6. 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.
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 following:

1. The name, position and duties of each direct care staff person.

2. The required training courses for each staff person.

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

66b - Training Plan Content *(continued)*

Plan of Correction ***Accept (08/17/2023)***

Annual training plan to be formulated per 2600.66b by 8-20-23 as current Relias plan does not meet requirement. The annual training plan will include the name, position and duties of each direct care staff person. It will include required training courses for each staff person and the date/time/location of the scheduled training or Relias course for each staff person for the current year. 2023 plan to be completed by 8-20-23. Plan to be updated annually by Executive Director or designee in accordance with 2600.66b.

Licensee's Proposed Overall Completion Date: *08/20/2023*

Implemented - 12/20/2023)

85a - Sanitary Conditions

7. Requirements

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

Description of Violation

On 7/7/23, at 2:50 pm, there was a soiled adult brief on top of the resident's dresser in room 516.

On 7/7/23, a container of leftover vegetables has been sitting on the counter in the first-floor Bistro area since the afternoon of 7/6/23.

Plan of Correction ***Accept (- 08/08/2023)***

Soiled brief was immediately removed from apartment 516. Executive Director reeducated resident to ring call bell for assistance when in need of incontinence care on 7-7-23. ED provided training to all nursing dept on 8-3-23 to monitor residents with incontinence needs to ensure cleanliness of apartments and ensure proper disposal of soiled items. Training provided to all departments on 8-3-23 during all staff meeting how to properly store and label all foods, including leftover foods. Dining Director or designee to audit Bistro, Main kitchen, and Memory care kitchenette for proper food storage and labeling 3 times week x 4 weeks, then weekly ongoing. Any deficiencies to be corrected immediately and staff provided with direction.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented - 12/20/2023)

96a - First Aid Kit

8. 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 fifth-floor wellness center does not include a thermometer, breathing shield, and eye coverings.

Plan of Correction ***Accept - 08/08/2023)***

Corrected immediately day of inspection. All required items listed in 96a were added to First Aid Kits in all

96a - First Aid Kit (continued)

locations of community on 7-7-23. First Aid kits will be audited by HWD or designee weekly x 4 weeks and monthly to ensure compliance ongoing. Ed provided training to all departments on 8-3-23 at all staff meeting.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 12/20/2023)

100a - Exterior - Free of Hazards

9. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

Electric grounding wire on the eleventh-floor Skyline Terrace has an exposed sharp end posing a hazard to residents.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Area of exposure properly corrected at time of inspection on 7-7-23. Maintenance Director retrained to observe such hazards during weekly community walk through ongoing.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented [redacted] 11/07/2023)

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

On 7/6/23, at 10:35 am, the temperature in the walk-in freezer on the eleventh floor was 2 degrees Fahrenheit.

On 7/6/23, at 10:49 am, there were two refrigerators in the Lafayette Lounge, the temperature in the first refrigerator was 42 degrees Fahrenheit and in the second the temperature was 51 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Thermometers replaced to ensure accuracy. Dining Director or designee will audit thermometers in Refrigerator and Freezers dedicated to dining daily. All Dining staff given education on proper temperatures for refrigerators and freezers on 8-3-23 at all staff meeting. Activities Director educated to 103f and assigned to monitoring lounge refrigerator/freezers ongoing and report any issues to maintenance director immediately on ongoing basis.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented [redacted] - 12/20/2023)

103g - Storing Food

11. Requirements

103g - Storing Food *(continued)*

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 7/6/23, at 10:31 am, a bag of breakfast sausages, a bag of chicken nuggets, a bag of onion rings, and a bag of mixed vegetables were opened and unsealed in the chef's freezer on the eleventh floor.

Plan of Correction ***Accept (- 08/08/2023)***

Executive Director audited Bistro and kitchen 2x week for 4 weeks starting 7-7-23 and ending on 8-4-23 and has found all items stored properly. Executive Director provided training on proper storage of refrigerated, frozen, and dry storage items to all departments on 8-3-23. Dining Director or designee to randomly inspect all food items for proper storage on ongoing basis.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented - 12/20/2023)

105g - Lint Removal and Duct Cleaning

12. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 7/7/23, at 3:22 pm, there was an approximate 1-inch accumulation of lint in the lint trap of the fourth-floor laundry dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept 08/08/2023)***

Lint removed and and vent cleaned day of inspection. Lint traps have been audited on random dates and times by ED x 4 weeks. Training for all housekeeping and memory care staff by 8-15-23. Memory Care Director and Maintenance Director to monitor on ongoing basis to ensure compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented - 12/20/2023)

107d - Procedure Emergency Management Agency Submission

13. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 3/17/21.

Plan of Correction ***Accept - 08/08/2023)***

Community Emergency Procedures were reviewed by ED and submitted to local emergency management on 8-1-23. Any changes to community procedures throughout year will be communicated to local emergency management immediately for review. ED to audit state compliance binder monthly to ensure compliance in submitting timely.

Licensee's Proposed Overall Completion Date: *08/04/2023*

107d - Procedure Emergency Management Agency Submission *(continued)*

Implemented [redacted] - 11/07/2023)

123c - Evacuation Diagrams

14. Requirements

2600.
123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 47 residents. However, there are no emergency evacuation diagrams posted on the first floor through sixth floor.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Corrected at the time of inspection on 7-7-23. Emergency evacuation diagrams have been posted on floors 1-6 and floor 11. ED to add to Tels monthly checklist for Maintenance director to check monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 11/07/2023)

124 - Notice to Fire Department

15. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Written notification to local fire department with all requirements provided to [redacted]., Deputy Fire Marshall on 8-1-23. ED will update Fire Marshall monthly and as needed with significant changes in evacuation needs to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented [redacted] - 11/07/2023)

141a 1-10 Medical Evaluation Information

16. 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 1's medical evaluation did not include the ability to self-administer medication.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Audit of all resident records completed on 7-31-23 to self identify non compliance. Order obtained from PCP to self administer specific medications. HWD or designee to audit for any changes throughout year to ensure changes are properly documented. ED and HWD to audit all new move ins prior to arrival and day of arrival to ensure all requirements are met and continued compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 11/07/2023)

144b - Policy on Smoking

17. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

There are no signs indicating whether or not smoking is permitted.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Resident contract, Appendix D, does include Anthology of KOP is a non smoking campus, with a complete non smoking policy. Corrected at time of inspection 7-6-23, signs placed on all public entrances that smoking is not permitted. ED/Maintenance Director or designee will audit monthly to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented [redacted] - 11/07/2023)

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

Resident 1 is prescribed Humalog 100 units inject subcutaneous daily per sliding scale, which was opened on 5/25/23.

183e - Storing Medications (continued)

According to the manufacturer's instructions, the medication must be used within 28 days or be discarded. However, on 7/7/23 at 1:40 pm, the medication was found in the fourth-floor medication cart.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Insulin was discarded upon inspection and new insulin pen placed in med cart. Insulin will be labeled with date opened and exchanged with new pen every 28 days as per manufacturers directions. All med tech and LPN staff retrained to insulin expiration dates by 8-15-23. Audits of med carts 3 times weekly by HWD or designee x 8 weeks, then monthly ongoing to ensure compliance.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] 12/20/2023)

184a - Resident's Meds Labeled

19. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident 2 is prescribed Nystatin 100,000 unit/gram powder apply topically two times daily. However, the pharmacy label on the medication bottle indicates apply topically four times daily.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Direction change label applied at time of inspection. LPN/med tech staff retrained to include when orders change they must use direction change stickers to alert all medication staff to changes day of inspection. Medication cart audit weekly by HWD or designee, medication to emar inspection x 8 weeks or until compliance achieved.

Licensee's Proposed Overall Completion Date: *09/15/2023*

Implemented [redacted] - 12/20/2023)

224a - Preadmission Screen Form

21. 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]/22; however, the resident's preadmission screening form was completed on 5/6/22.

Repeat Violation Date: 8/24/22.

Plan of Correction ***Accept [redacted] 08/08/2023)***

Resident took financial possession of apartment on 3-31-22 but did not physically move in until 5-16-23. Resident

224a - Preadmission Screen Form (continued)

was assessed prior to financial possession but did not move in. Resident was seen and reassessed 5-6-22 to ensure still appropriate for PCH. ED completed audit of all resident records on 7-31-23 to self identify records out of compliance, noted in the record. ED or HWD to review all new move ins prior to move in date to ensure pre-screen compliance ongoing.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] 11/07/2023)

225a - Assessment 15 Days

22. 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]/22.

Repeat Violation Date: 8/24/22 and 10/12/22.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

The assessment for Resident 1 was self identified not completed by community and finalized on 1-12-23. All resident records again audited and completed by 7-31-23 , and deficiencies will be corrected by 8-15-23. All new move ins will be audited by ED or designee prior to move in date, on move in date, and 10-14 days after move to ensure ongoing compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted]/07/2023)

231e - No Objection Statement

23. 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 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/22. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/23. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Repeat Violation Date: 8/24/22.

Plan of Correction ***Accept [redacted] - 08/08/2023)***

Assessments of residents 1 and 2 have been amended to reflect there is no objection by resident and family related to residency in a SDU. All resident records audited for 2600 compliance , completed on 7-31-23. ED or designee to audit each new move ins records prior to admission, on day of move in , and 10-14 days after move in for continued compliance.

231e - No Objection Statement *(continued)*

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] 11/07/2023)

233c - Key-Locking Devices

24. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the main exit door from the Secure Dementia Care Unit (SDCU) to the Personal Care on the fourth floor.

Plan of Correction ***Accept [redacted] 08/08/2023)***

Corrected at time of inspection on 7-7-23. Directions to exit SDU were posted and understandable/clear for visitors in community. Memory Care Director was provided with explanation of 233c and has clear understanding of posting requirement. Memory Care Director to ensure continued compliance and ensure directions posted at all times.

Licensee's Proposed Overall Completion Date: *08/04/2023*

Implemented [redacted] - 11/07/2023)

236 - Staff Training

25. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had zero hours of training in dementia care during the 2022 training year.

Plan of Correction ***Accept [redacted] /08/2023)***

Direct Care staff A will receive 6 additional hours of dementia training by 8-15-23 BOD will audit all staff training records monthly to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *08/15/2023*

Implemented [redacted] - 11/07/2023)

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

January 12, 2024

[redacted]
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 12/11/2023 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**: *08/10/2023*

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]

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**: *69* **Waking Staff**: *52*

Inspection Information

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

Reason: *Complaint, Provisional, Incident, Monitoring* **Exit Conference Date**: *12/11/2023*

Inspection Dates and Department Representative

12/11/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128* **Residents Served**: *43*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *28* **Residents Served**: *22*

Hospice

Current Residents: *4*

Number of Residents Who:

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

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

Have Mobility Need: *26* **Have Physical Disability**: *0*

Inspections / Reviews

12/11/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/30/2023*

Inspections / Reviews *(continued)*

01/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/11/2024*

01/12/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/10/2024*

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

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 12/11/23, at 9:54 AM, the following resident's empty medication cards and containers were unlocked, unattended, and accessible on top of the medication cart in the memory care unit;

- *Resident #1 - Jardiance 10 MG Tablet prescription card and 2 Carbidopa-Levodopa 25-100 Tab prescription cards,*
- *Resident #2 - Escitalopram 10 MG Tab prescription cards,*
- *Resident #3 - an empty bottle of #30 Prednisone 5 MG Tab,*
- *Resident #4 - an empty box of Cough DM ER 30 MG/5 ML Susp.*

Plan of Correction ***Accept[redacted] - 01/08/2024)***

Medication labels were immediately removed from med cart at time of inspection. Med tech on that med cart on 12-11-23 immediately re-educated at the day of inspection that all medication labels that need to be shredded need to be stored inside med cart during the med pass. All med techs provided with same in-service week of 12-18-23 and last training held for med techs 12-29-23. All staff meeting 1-4-24 will review with all nursing staff. All nursing staff to be educated so if they see confidential material unattended they can remove from public view.

Proposed Overall Completion Date: 01/05/2024

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

Implemented ([redacted] - 01/12/2024)

181f - Record of Medication

2. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 12/11/23, resident #5's record did not include a current list of medications. The list in the resident's record included medications that had been discontinued by the resident's physician.

Plan of Correction ***Accept[redacted] - 01/08/2024)***

Resident # 5 stated that medication was discontinued by MD one week prior to 12-11-23 and she forgot to stop by Wellness office. Regulation reviewed with resident #5. Executive Director provided education to each resident that self-administers medication on 12-12-23, 12-15-23, and 12-19-23 of regulation 181f. Executive Director to create written educational outlines for all new move ins and existing residents outlining regulations for self-administering medications. Health and Wellness Director or designee to review with residents who self-administer during self-administer reassessments per Anthology policy. Heath and Wellness Director to review self administration residents monthly x 3 months to ensure compliance.

Proposed Overall Completion Date: 01/05/2024

181f - Record of Medication *(continued)*

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

Implemented ([redacted] - 01/12/2024)