

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

January 22, 2024

[REDACTED]
PAULS RUN INC
[REDACTED]

RE: PAUL'S RUN
9896 BUSTLETON AVENUE
FLOORS 3 & 4; BUILDING B
PHILADELPHIA, PA, 19115
LICENSE/COC#: 17699

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/04/2023, 12/05/2023 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: PAUL'S RUN License #: 17699 License Expiration: 07/24/2024
 Address: 9896 BUSTLETON AVENUE, FLOORS 3 & 4; BUILDING B, PHILADELPHIA, PA 19115
 County: PHILADELPHIA Region: SOUTHEAST

Administrator

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

Legal Entity

Name: PAULS RUN INC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: Other Date: 09/08/1981 Issued By: City of Philadelphia, L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 95 Waking Staff: 71

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Incident Exit Conference Date: 12/05/2023

Inspection Dates and Department Representative

12/04/2023 - On-Site: [REDACTED]
 12/05/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 170 Residents Served: 95

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: 94
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: [REDACTED]
 Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

12/04/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/30/2023

01/10/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 01/22/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 01/15/2024

Inspections / Reviews (*continued*)

01/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/22/2024

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 01/18/2024

01/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/22/2024

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

15b - Supervisor Plan

1. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [REDACTED], at [REDACTED], the Department approved a plan of supervision for staff member A with the requirement that the home conduct resident interviews about the care provided by staff member A and that the interviews would be used as a training tool during weekly meetings between management and staff member A. The home did not implement the "resident interviews" portion of the plan of supervision. Management states the weekly meetings were held and provided the dates of the meetings, but the training portion of the meetings was to be derived from the resident interviews. Without the interviews, the weekly meetings did not accomplish the intended goal. Therefore, the home did not implement the approved plan of supervision or suspend the staff person involved in the alleged incident.

Plan of Correction

Accept [REDACTED] - 01/12/2024)

- The PCHA will be responsible for ensuring all requirements for the plan of supervision are followed with in the time frame that is set in the Plan of Supervision.
- The PCHA will review the Plan of Supervision with the Personal Care Unit Manager throughout the Plan of Corrections to ensure all requirements are being met.
- If the PCHA has questions about any requirements of the Plan of Supervision the PCHA will contact a DHS to ask for assistance or clarification.
- This will occur whenever a Plan of Supervision is put into place.
- On 12/22/23 The PCHA interviewed residents currently assigned to Staff member A in the month of December, which are the same residents she was assigned to, under the Plan of Supervision. The residents interviewed are cognitively intact and familiar with Staff Member A. Staff member A works 11p-7am and the residents interviewed were happy with the care provided to them by Staff member A.

Licensee's Proposed Overall Completion Date: 01/10/2024

Implemented [REDACTED] - 01/22/2024)

16c - Written Incident Report

2. 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], at [REDACTED] resident [REDACTED] had an unwitnessed fall in [REDACTED] apartment. The resident was sent to the hospital via emergency transport and was admitted. The home did not report this incident to the Department until [REDACTED].

Plan of Correction

Accept [REDACTED] - 01/10/2024)

- Nursing staff was reminded, on 12/5/23, by the nursing management team, that the Unit manager and Personal Care Administrator must be notified immediately if a resident is sent out to the hospital.
- The Personal Care Unit Manager is responsible for reporting incidents to the state.

16c - Written Incident Report (continued)

- The Personal Care Unit manager in-serviced the nursing staff, on 12/27/23 on what a state reportable condition is and who the nursing management team contact information.

Licensee's Proposed Overall Completion Date: 12/29/2023

Implemented [REDACTED] - 01/22/2024)

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.

Description of Violation

Direct care staff person B received only 6.75 hours of annual training in training year 2022.

Plan of Correction

Accepted [REDACTED] 01/10/2024)

- The Personal Care Unit Manager spoke to staff person B to notify [REDACTED] that [REDACTED] 12 hours of annual training was not complete.
- The PCHA gave Staff member B an education, 12/20/23 on the importance of completing annual trainings. Staff member B was asked to become current on [REDACTED] training by 12/31/23.
- Quarterly checks will done, by the PCHA to ensure staff is completing and/or attending all assigned trainings. This will be ongoing.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [REDACTED] 01/22/2024)

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.

65f - Training Topics (continued)

- 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 B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, care for residents with dementia and cognitive impairments, personal care service needs of the resident and safe management techniques during training year 2022.

Plan of Correction

Accept [redacted] - 01/10/2024)

- *The PCHA checked the training site (Relias) to ensure all required trainings were available to Staff member B and added any trainings that were not available to Staff member B on 12/20/23.*
- *The PCHA spoke to the Director of Human Resources, 12/20/23, to ensure when new direct care staff members were added to the training site (Relias) the correct required trainings are available.*
- *The Human Resources Director was given a list of the required trainings 12/26/23, for all direct care staff to ensure it is available to all Personal Care direct care staff members.*

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [redacted] - 01/22/2024)

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 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 during training year 2022.

Staff person B did not receive training in 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, emergency preparedness procedures and recognition and response to

65g - Annual Training Content (continued)

crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, during training year 2022.

Staff person C did not receive training in 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, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention, during training year 2022.

Plan of Correction

Accepted [redacted] 01/10/2024)

- The Personal Care Administrator spoke to the Director of Facilities about Fire safety Training by a Fire Safety expert on 12/5/23.
 - The Director of Facilities has schedule for the Train to Trainer by a fire safety expert on 1/17/23.
 - The Director of Facilities will schedule in person Fire safety training for Personal care staff and any new direct care staff and ancillary staff members, going forward. this will be ongoing.
- The training site (Relias) was audited 12/28/23 by The Liberty Lutheran Human Resource Administrative Assistant to ensure all required trainings are available to all direct care staff members and ancillary staff.
- The Liberty Lutheran Human Resource Administrative Assistant created training plans for Personal Care direct care staff and ancillary staff members.

Proposed Overall Completion Date: 01/17/2024

Licensee's Proposed Overall Completion Date: 01/17/2024

Implemented [redacted] - 01/22/2024)

131f - Fire Extinguisher Inspection

6. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the Ford bus, used for transporting residents, did not have a tag showing the last inspection date.

Plan of Correction

Accepted [redacted] - 01/10/2024)

- Director of Facilities replaced the fire extinguisher 12/5/23 on the ford, with a fire extinguisher that has been inspected within the last year.
- The vehicle fire extinguisher was inspected 12/27/23.
- The Facilities Director has added the vehicle fire extinguisher to the annual inspection list for all facility fire extinguishers.

Licensee's Proposed Overall Completion Date: 12/28/2023

131f - Fire Extinguisher Inspection (*continued*)

Implemented [REDACTED] - 01/22/2024)

132b - Safety Inspection/Fire Drill

7. Requirements

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The last fire safety inspection and drill observed by a fire safety expert was conducted on 05/22/23. The previous fire safety inspection and drill was conducted on 04/08/22.

Plan of Correction

Accepted [REDACTED] 01/10/2024)

- The Facility Director will have an electronic reminder to schedule the annually Fire safety inspection and fire drill, which is and will be conducted by [REDACTED].
- Inspection scheduled [REDACTED] for [REDACTED] Confirmation is attached

Annually

Licensee's Proposed Overall Completion Date: 12/27/2023

Implemented [REDACTED] - 01/22/2024)

132c - Fire Drill Records

8. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drills conducted on 10/30/23, 09/30/23, 01/28/23, 12/27/22 and 11/28/22 do not include the number of residents in the home at the time of the drill and any problems encountered.

Plan of Correction

Accepted [REDACTED] - 01/10/2024)

- The Facility Director was made aware 12/5/23, that the Fire Drill Record did not include the number of residents evacuated.
 - On 12/21/23 The facility director contacted Croker, the company used for fire drills, and communicated the issue with the fire drill paperwork.
- The DHS recommended Fire Drill log will be used to audit fire drill paperwork coming from Croker, monthly.
- The Facility Director will follow up with Croker if any Fire Drill paperwork is not in compliance.

132c - Fire Drill Records (continued)

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [REDACTED] 01/22/2024)

132d - Evacuation

9. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

During the following drills, not all residents were evacuated;

- [REDACTED] Residents evacuated, [REDACTED] residents in the home,
- [REDACTED] Residents evacuated, [REDACTED] residents in the home,
- [REDACTED] Residents evacuated, number of residents in the home not listed,
- [REDACTED] Residents evacuated, number of residents in the home not listed,
- [REDACTED] Residents evacuated, number of residents in the home not listed,
- [REDACTED] Residents evacuated, [REDACTED] residents in the home,
- [REDACTED] Residents evacuated, [REDACTED] residents in the home,
- [REDACTED] Residents evacuated, [REDACTED] residents in the home.

Plan of Correction

Accept [REDACTED] - 01/10/2024)

- The Facility Director was made aware of the 12/5/23, that the Fire Drill Record not all residents were evacuated.
- On 12/21/23 The facility director contacted Croker, the company used for fire drills, and communicated the issue that on 8 fire drills not all residents were evacuated and going forward all residents must be evacuated during fire drills.
- The DHS recommended Fire Drill log will be used to audit fire drill paperwork coming from Croker.
- The Facility Director will follow up with Croker if any Fire Drill paperwork is not in compliance.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [REDACTED] 01/22/2024)

132f - Alternate Exit Routes

10. Requirements

2600.

132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The B2 stairwell was the only exit route used during the fire drills held from January 2023 to March 2023.

Repeat Violation: 05/23/22.

Plan of Correction

Accept [REDACTED] - 01/10/2024)

- The Facility Director was made aware of the 12/5/23, that the Fire Drill Record reflected only stairwell B was

132f - Alternate Exit Routes (continued)

used as an exit route.

- On 12/21/23 The facility director contacted Croker, the company used for fire drills, and communicated the issue with the fire drill paperwork.
- The DHS recommended Fire Drill log will be used to audit fire drill paperwork coming from Croker. This will be done monthly.
- The Facility Director will follow up with Croker if any Fire Drill paperwork is not in compliance.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [redacted] - 01/22/2024)

132g - Fire Drills Days/Times

11. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills completed on 07/27/22, 06/01/22 and 05/11/22 were all completed on a Wednesday.

Plan of Correction

Accepted [redacted] - 01/10/2024)

- The Facility Director was made aware 12/5/23, that the Fire Drill Record documented 3 fire drills done on a Wednesday 3 months in a row.
- On 12/21/23 The facility director contacted Croker, the company used for fire drills, and communicated the issue with the fire drill paperwork.
- The DHS recommended Fire Drill log will be used to audit fire drill paperwork coming from Croker, monthly.
- The Facility Director will follow up with Croker if any Fire Drill paperwork is not in compliance.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [redacted] - 01/22/2024)

190a - Completion Medication Course

12. Requirements

2600.

190a - Completion Medication Course (continued)

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person D has not maintained compliance with the annual practicum requirement of the Department-approved medication administration course. Staff person B administered medications to residents to include the following:

On [redacted] during the [redacted] medication administration time to resident [redacted]
On [redacted] at [redacted], resident [redacted] PRN medication.

Repeat Violation: 10/31/22.

Plan of Correction

Accept [redacted] - 01/10/2024)

- The Unit Manger was informed, 12/5/23, that Staff person D's Medication Administration paperwork was out of compliance.
 - The Unit manager contacted Staff member D and informed Staff member D her medication Administration was out of compliance and could not give medication to residents. [redacted]
 - The unit manager offered Staff member D med admin training and to work as a C.N.A. until traing was complete.
 - Staff member D refused the offer, and stated [redacted] Full Time job would perform the training.
 - The unit manager asked for [redacted] documentation by 12/29/23.
- Medication Administration paperwork received 12/29/23

Licensee's Proposed Overall Completion Date: 12/29/2023

Implemented [redacted] - 01/22/2024)

227a - Support Plan 30 Days

13. Requirements

2600.

227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident [redacted] was admitted on [redacted]; however, the resident's initial support plan was not completed until [redacted]

Plan of Correction

Accept [redacted] - 01/10/2024)

227a - Support Plan 30 Days (continued)

- The nursing management team was made aware the date for Resident#3's service plan was out of compliance.
- The nursing management team investigated why this had happened and the resident had gone out to the hospital before the RASP was signed.
- Nursing management will audit the RASP due every month to ensure all RASPs are completed.
- This will be ongoing.

Licensee's Proposed Overall Completion Date: 12/20/2023

Implemented [REDACTED] 01/22/2024)

227d - Support Plan Medical/Dental

14. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident [REDACTED], dated 11/04/23, indicates A (Independent) under the Personal Care Needs and Degree column for Turning and positioning in bed/chair; however, "Bed Enabler for self positioning" is listed under the Plan to Meet Service Need column. Further, the Resident Support Plan does not indicate the following:

- The specific need for the device,
- The intended Use,
- Any risks associated with the device,
- The resident's ability to use the device safely for the intended purpose,
- Identification of the specific device to be used,
- If a cover is required to meet FDA guidelines.

Plan of Correction

Accept [REDACTED] - 01/10/2024)

- On 12/21/23- The Personal Care Administer and Personal Care Unit Manager have in-serviced andl educated the nursing staff on the proper documentation of Bedside Mobility Devices on the RASP, the in-service will also include the Bedside Mobility Device policy.
- See attached.

Licensee's Proposed Overall Completion Date: 12/29/2023

Implemented [REDACTED] 01/22/2024)