

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

April 18, 2024

[REDACTED], ADMINISTRATOR
WILLOW VALLEY COMMUNITIES
[REDACTED]
[REDACTED]

RE: MEADOW RIDGE AT WILLOW
VALLEY
925 WILLOW VALLEY LAKES DRIVE
WILLOW STREET, PA, 17584
LICENSE/COC#: 32205

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/27/2024, 03/28/2024 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: MEADOW RIDGE AT WILLOW VALLEY **License #:** 32205 **License Expiration:** 07/31/2024

Address: 925 WILLOW VALLEY LAKES DRIVE, WILLOW STREET, PA 17584

County: LANCASTER **Region:** CENTRAL

Administrator

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

Legal Entity

Name: WILLOW VALLEY COMMUNITIES

Address: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 **Date:** 06/19/2006 **Issued By:** West Lampeter Township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 78 **Waking Staff:** 59

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:** 0

Reason: Renewal **Exit Conference Date:** 03/28/2024

Inspection Dates and Department Representative

03/27/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 156 **Residents Served:** 78

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:** 78

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

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

Inspections / Reviews

03/27/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/13/2024

04/17/2024 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 04/17/2024

Reviewer: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 04/24/2024

Inspections / Reviews *(continued)*

04/18/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/17/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

81b - Resident Personal Equipment

1. Requirements

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident 1, Resident 3 and Resident 6 utilize a bed side mobility device to aid in positioning and transferring in and out of bed. However, the mobility devices for all three residents were not securely fastened to the bed and were uncovered with openings that measured greater than 4 3/4 inches as recommended by the FDA.

Plan of Correction

Accept (████) - 04/17/2024)

Requirements

2600.81.b.

Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident 1, Resident 3 and Resident 6 utilize a bed side mobility device to aid in positioning and transferring in and out of bed. However, the mobility devices for all three residents were not securely fastened to the bed and were uncovered with openings that measured greater than 4 3/4 inches as recommended by the FDA.

Why did this happen?

Bed canes applied to 3 beds were applied without using the manufacturer guidelines or the guidelines provided by DHS, Use of Bedside Mobility Devices in PCH and ALR from 6/26/2023.

What do we do right now to fix the problem?

Who - On March 28th, Administrator provided manufacture guidelines (with diagrams) to maintenance team member on correct application of the bed cane. Reviewed the Use of Bedside Mobility Devices in PCH and ALR (with diagram) with maintenance team member. Maintenance team member corrected bed cane application for all 3 beds per the guidelines provided.

What - Education provided by Administrator to teams working in Personal Care on the proper application and installation of bed canes according to the manufacturer and DHS guidelines. Handouts provided with meeting minutes. Education provided to residents in at Town Hall Meeting on April 10, 2024 on use of bed canes and installation requirements including covering the bed cane to eliminated opening where risk of entrapment could occur. Town Hall meeting minutes will be distributed in all resident mailboxes.

When - Education to Nursing Team Members was provided verbally on March 28th after exit, again verbally on April 3rd and 4th at Monthly PC Team Member meetings. Written education about plan of correction is in progress week of 4/8/24 for all Team Members at Meadow Ridge to review and sign off. This will be on paper, emailed to all team leaders, and added to Relias for all PC Team members to review.

How do we prevent this from happening again?

Who - Administrator will assign a quarterly audit to nursing team members to be completed for all bed canes being used. Maintenance and Occupational Therapy have been provided with a copy of the manufacturer installation guidelines and the DHS provided guidelines. Administrator contacted electric bed vendor on 4/10/24 to inquire about other options for bed mobility devices for the electric beds being added with the renovation project. Awaiting a response.

What - When options are known for bed mobility devices that are appropriate for electric beds and compliant with DHS guidance, an order will be placed for ten (10) bed mobility devices for Meadow Ridge to replace the bed canes currently in use and to have on hand in case there is a future need.

81b - Resident Personal Equipment (continued)

When – Quarterly Audit of bed mobility devices (January, April, July, October). First will be April 2024. An order will be placed for 10 bed mobility devices when options are known. Installation of approved model will occur upon arrival, projected estimation will be June 2024 (dependent on vendor supply and shipping delays)

Timeline/Work Plan

Action - Owner - Completion Date

Corrected current Bed canes - Maintenance - 3/28/24

Education for Team Members - Administrator - 4/12/24

(and added in Relias indefinitely)

Contact vendor for different options - Administrator - 4/10/24

Purchase appropriate option - Administrator - pending

Updated current Audit tool - Administrator - 4/11/2024

Audit devices quarterly - RCAs - April 2024 then quarterly

Education to Residents - Administrator/ Nurse Coordinator - 4/10/24

(At Town Hall meeting and minutes to all residents)

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented (█) - 04/18/2024)

88a - Surfaces

2. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 3/28/24, there was a hole, approximately 4 inches high and 5 inches wide, in the drywall behind Resident 6's recliner in his/her room. The hole was impeding on a 4-plug outlet, that had four devices plugged into the outlet.

Plan of Correction

Accept (█) - 04/17/2024)

Requirements

2600.88.a.

Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 3/28/24, there was a hole, approximately 4 inches high and 5 inches wide, in the drywall behind Resident 6's

88a Surfaces (continued)

recliner in his/her room. The hole was impeding on a 4 plug outlet, that had four devices plugged into the outlet.

Why did this happen?

Hole found by Surveyor upon individual resident interview. The was from her recliner pushing against the wall near the outlet when reclined using the chair remote.

What do we do right now to fix the problem?

Immediately after knowledge of the hole on 3/28/2024, Administrator called mainentance and drywall was repaired and spackled within 1 hour.

Who Administrator/Maintenance

What repaired drywall and spackled within an hour of knowledge of hole

When within 1 hours of knowledge of hole after Surveyor noted hole

How do we prevent this from happening again?

Who Administrator/Nurse Coordinator has assigned environmental inspections to nursing team members to complete quarterly for all resident rooms and common areas at Meadow Ridge.

What Audit tools currently are in use and will continue. Written education has been provided to all team members about immediately putting in a work order when there is a noted issue anywhere in the building with floors, walls, ceilings, windows, doors and other surfaces that must be clean, in good repair and free of hazards.

When Audits are in progress week of 4/8/24 and will continue quarterly. Education was provided verbally at PC TM meeting 4/3 and 4/4. Written education provided for all departments and team members on 4/10/24. Education was provided to residents at Town Hall meeting on 4/10/224 and minutes will be distributed to all residents. Audit of room 422 completed on 4/12/24.

Timeline/Work Plan

Action - Owner - Completion Date

Hole repaired Administrator/Maintenance 3/28/24

Education to Team Members Administrator 3/28/24

Quarterly Audits in progress Nursing Team Members 4/2024 and in progress

Written Education to All Teams Administrator/Department Team Leaders 4/10/24

Education to Residents Administrator 4/10/24

(Town Hall and minutes)

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented (█) - 04/18/2024)

91 - Telephone Numbers

3. Requirements

2600.

- 91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

91 - Telephone Numbers (continued)

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in multiple residents' rooms including Resident 5 and 6.

Plan of Correction

Accept (█) - 04/17/2024)

Requirements**2600. 91.**

Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in multiple residents' rooms including Resident 5 and 6.

Plan of Correction**Why did this happen?**

Standard Meadow Ridge practices were not followed - All phones within the facility are to have a sticker placed with all the required emergency numbers. If no phone is present in a resident's room, the emergency numbers must be posted easily and accessible in each resident's rooms.

With ongoing renovations, residents have moved to temporary rooms, some with no phones. Some residents elect not to have a landline, hard-wired phone and only use a personal cell phone. Staff did not realize the emergency numbers were not in the resident rooms and staff did not offer these numbers to be placed on the resident's personal cell phones. This was an oversight.

What do we do right now to fix the problem?

Who – Administration

What – Printed more stickers with emergency phone numbers. Staff offered to add sticker to resident's personal cell phones on 3/28/24. A sticker with the emergency numbers was applied to both residents 5 and 6 room refrigerators since they do not have a landline, hard-wired phone present in their rooms.

When – 3/28/24

How do we prevent this from happening again?

The sticker with the required emergency numbers has been added to the front of all resident room refrigerators. All residents were provided with a paper hand out with the required emergency numbers to keep in their walkers or place in the rooms in their preferred area for quick access. Staff offered to assist with downloading the emergency numbers onto the resident's personal cell phones.

Who – Administration and Meadow Ridge Nursing Staff

What – Education was provided to all PC Team Members and Residents about the DHS regulation 91 and the requirement to have the emergency numbers posted on each phone in the building and posted in each room in case a resident does not have a phone. Staff education to offer to add emergency numbers to residents cell phones. Residents educated in Town Hall meeting and with minutes about regulation 91. Residents were provided with an additional paper copy of the emergency numbers to place where they prefer in their rooms, in their walkers, or on their person. Staff applied a sticker on all resident refridgerators with the emergency numners. Room Inspection Audit was updated to clarify where stickers will be placed in resident rooms and offering to add numbers into resident cell phones.

When

91 - Telephone Numbers (continued)

– Staff education verbally on 3/28 after survey exit, on 4/3 and 4/4 Nursing staff were educated verbally at the Monthly Team Meeting, DHS education packet provided to all departments on 4/10/24. Room inspection Audit updated again 4/12/24. Residents were educated in Town Hall meeting on 4/8/24 and paper copy of emergency numbers was provided and minutes were provided thereafter to all residents which included a paper copy of the emergency numbers. Stickers were placed on every resident room refrigerator between 3/28/24 and 4/8/2024.

Timeline/Work Plan

Action - Owner - Completion Date

Placed emergency numbers stickers - Nursing Staff - 3/28/24-4/8/24

(on resident 5 & 6 refrigerators)

Education to Team Members - Administrator - 3/28/24 – 4/10/24

Residents Educated - Administrator/Nurse Coordinator - 4/10/24

Room Inspection Audit 2nd edit - Administrator - 4/12/24

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented () - 04/18/2024)

102d - Grab/Hand/Assist Bar/Slip-Resistant Surface

4. Requirements

2600.

102.d. Toilet and bath areas must have grab bars, hand rails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, handrail or assist bar near the toilets in two stalls in the ladies' bathroom and 1 toilet in the men's bathroom located on the first floor. These bathrooms are utilized by the residents.

Plan of Correction

Accept () - 04/17/2024)

Requirements

2600.102.d.

Toilet and bath areas must have grab bars, handrails or assist bars. Bathtubs and showers must have slip-resistant surfaces.

Description of Violation

There is no grab bar, handrail or assist bar near the toilets in two stalls in the ladies' bathroom and 1 toilet in the men's bathroom located on the first floor. These bathrooms are utilized by the residents.

Why did this happen?

Since building was built in 2006, there has not ever been grab bars in the additional stalls in the 1st floor public bathrooms. One stall in each public bathroom for men and for women have assist bars and is to ADA codes. This is the first survey since the building opened that cited this concern.

What do we do right now to fix the problem?

A waiver was requested after contacting the Regional Licensing Director and this was the suggestion on 4/4/24.

Who – Willow Valley Senior VP of Healthcare/Administrator

What – Submitted a requested for a waiver for 2600.102(d)

102d Grab/Hand/Assist Bar/Slip Resistant Surface (continued)

When 4/4/2024 waiver request was sent to DHS

How do we prevent this from happening again?

Waiting on the outcome and decision of the waiver request at this time. If denied, renovations of the 1st floor public bathroom are planned to start with Phase 4 which starts May 20th, 2024. This area will be closed to the public from May 20th, 2024, until November 1st, 2024

Who Renovation Team

What 3 stalls on 1st floor will have bars added

When Between May 20th and November 1st, 2024 during phase 4 of the current renovation project. Area will be closed during phase 4.

Timeline/Work Plan

Action - Owner - Completion Date

Contacted Regional Licensing Director Senior VP of Healthcare/Administrator 4/2/24 4/4/24

Submitted a Request for Waiver Administrator 4/4/24

Bars added if needed Renovation Team between May 20th and November 1st, 2024

Included - is the opinion of the current Architect completing the Meadow Renovations Project -

Per the International Building Code 2018 PA, each of these bathrooms include a minimum of one accessible water closet and one accessible lavatory that complies with the ANSI 117.1 09 (local jurisdiction), ADA (Federal Dept of Justice), and FHA (by Safe Harbor) standards. In addition, they comply with PA Title 55 Chapter 2600.102(d) which states that the "Toilet and bath area must have grab bars, hand rails or assist bars."

**Both the Men's and the Women's bathrooms meet this requirement with grab bars at the accessible water closet within the "toilet and bath area." For example, a person does not need to use a separate bathroom if they need grab bars.

Licensee's Proposed Overall Completion Date: 05/20/2024

Implemented (█) - 04/18/2024)

107d - Procedure Emergency Management Agency Submission

5. 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 written emergency procedures were submitted to the local emergency management agency on 4/11/22 and not again until 11/2/2023.

Plan of Correction

Accept (█) - 04/17/2024)

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 written emergency procedures were submitted to the local emergency management agency on 4/11/22 and not again until 11/2/2023.

Why did this happen?

107d Procedure Emergency Management Agency Submission (continued)

Written emergency procedures were not sent to the local emergency management agency by 365 days after 4/11/2022 submission. Sent 11/2/2023, which was outside the acceptable timeframe.

What do we do right now to fix the problem?

Who WVC Safety and Security Manager and Administrator

What Established WVC Safety and Security Manager will send the WVC emergency procedure to the local emergency management agency annually

When Established on 4/1/2024 that every November 1st annually the WVC emergency procedure will be sent to the local emergency management agency

How do we prevent this from happening again?

Who WVC Safety and Security Manager

What Will send the WVC emergency procedure to the local emergency management agency annually

When Every November 1st annually the WVC emergency procedure will be sent to the local emergency management agency

Timeline/Work Plan

Action - Owner - Completion Date

Established who will be responsible Safety and Security Manager/Administrator 4/1/24

WVC Emergency Procedure sent out Safety and Security Manager Annually

(November 1st every year to the Local Emergency Manager Agency)

All Team Members and Residents were updated on this citation and plan of correction Administrator 4/10/24

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented [redacted] - 04/18/2024)

185a - Implement Storage Procedures

6. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 3/28/24, the following discrepancies between Resident 2' s glucometer numbers and medication administration record (MAR) were observed:

On 3/20/24, the 4 pm blood sugar reading recorded in the MAR [redacted]. However, this reading was not in the resident's glucometer.

On 3/20/24, the 8pm blood sugar reading recorded in the MAR was [redacted]. However, the reading in the glucometer was [redacted]

On 3/27/24, the 11am blood sugar reading recorded in the MAR was [redacted]. However, the reading in the glucometer was [redacted]

Repeated Violation 11/21/22

185a - Implement Storage Procedures (continued)

Plan of Correction

Accept () - 04/17/2024)

Requirements**2600.185.a.**

The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 3/28/24, the following discrepancies between Resident 2' s glucometer numbers and medication administration record (MAR) were observed:

On 3/20/24, the 4 pm blood sugar reading recorded in the MAR [REDACTED]. However, this reading was not in the resident's glucometer.

On 3/20/24, the 8pm blood sugar reading recorded in the MAR was [REDACTED]. However, the reading in the glucometer was [REDACTED].

On 3/27/24, the 11am blood sugar reading recorded in the MAR was [REDACTED]. However, the reading in the glucometer was [REDACTED].

Why did this happen?

Two Team Member incorrectly transcribed glucometer reading to the Medication Administration Record (MAR) a total of three times for one resident. Team Member did not document the readings immediately and may have been distracted or forgot the number when transferring this information to the MAR.

What do we do right now to fix the problem?

Who – Nurse Coordinator with Nurses who made errors

What – Written Education was reviewed with Nurses making the errors with corrective action to record the glucometer readings into the MAR immediately and not to delay avoiding errors.

When – 4/11/2024

How do we prevent this from happening again?

Who – Administrator and Nurse Coordinator and Nursing Team

What – Education was provided verbally to nursing team on 3/28/24 after survey exit. Education provided to all nursing team members on 4/3/24 and 4/4/2024 at Monthly Team Member Meeting. Education provided to residents on citation and plan of correction at Town Hall on 4/10/24. Education provided to all team members on 4/10/24. Nursing Team will complete a weekly audit checking the glucometers against the MARs with appropriate follow up with Nurse Coordinator/Administrator if discrepancies are found.

Audit Spreadsheet for Glucometer Control Checks updated to include checking values with MAR

When – Individual education verbal 3/28/24, Nursing Team education 4/3/24 and 4/4/24. All team members education on 4/10/24. Resident education on 4/10/24. Audit will occur weekly as of 4/11/24 and thereafter.

Audit spreadsheet was updated on 4/11/24. Resident #2 audit 4/11/24.

Timeline/Work Plan**Action - Owner - Completion Date**

Individual Nurse Team Member Education - Nurse Coordinator - 4/11/24

Nursing Team Members Education (Verbal) - Administrator/Nurse Coord. - 3/28/24, 4/3 & 4/4/24

All Team Members Education - Administrator - 4/10/24

Resident Education - Administrator/Nurse Coord. - 4/10/24

Audit Spreadsheet updated - Nurse Coordinator - 4/11/24

Audit of Glucometer/MAR for resident #2 - Administrator/Nurse Coord. - 4/11/24 and weekly

185a - Implement Storage Procedures (continued)

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented [redacted] - 04/18/2024)

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident 1 is prescribed [redacted] daily in the evenings and to hold if systolic pressure is less than [redacted].
On [redacted] Resident 1's systolic pressure was [redacted]. However, the medication was not administered to resident on these days.

Plan of Correction

Accept [redacted] - 04/17/2024)

Requirements

2600.187.d.

The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 is prescribed [redacted] daily in the evenings and to hold if systolic pressure is less than [redacted]. On [redacted] Resident 1's systolic pressure was [redacted]. However, the medication was not administered to resident on these days.

Why did this happen?

Nurse did not interpret the doctor ordered parameters correctly and held the medication at 100 three times

What do we do right now to fix the problem?

Who - Nurse Coordinator and Administrator with nurses

What - Nurses were verbally educated on 3/28/24 after survey exit on importance of reading orders and parameters thoroughly.

When - 3/28/24 after survey exit

How do we prevent this from happening again?

Who - Administrator and Nurse Coordinator and Nursing

What - Verbal Education on citation 187 (d) reviewed at Monthly Team Member meeting on 4/3/24 and 4/4/24.

Team Member education on 4/10/24. Resident education on 4/10/24. Audit Metoprolol MAR and BP Parameters will occur weekly for 6 weeks by nurses

When - 3/28/24, 4/3/24 & 4/4/24, and 4/10/24. Audit started for 3/29/24-4/12/24 then weekly for 6 weekly

Timeline/Work Plan

Action - Owner - Completion Date

Education to Nurses - Administrator/Nurse Coordinator - 3/28/24, 4/3/24, 4/4/24

Education with Individual Nurse with errors- Nurse Coordinator - 4/8/24

Education to Residents - Administrator/Nurse Coordinator - 4/10/24

Audit of MARs for Metoprolol (3/29/24-4/12/24) - Administrator - 4/12/24

(Metoprolol Suc Tab 50mg ER with parameters to hold for SBP less than 100)

187d Follow Prescriber's Orders (continued)

Licensee's Proposed Overall Completion Date: 04/12/2024

Implemented ([REDACTED]) - 04/18/2024