Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

July 10, 2024

[REDACTED], COO
HARRISON SENIOR LIVING OF COATESVILLE LLC
300 STRODE AVENUE
COATESVILLE, PA, 19320

RE: HARRISON SENIOR LIVING OF COATESVILLE
300 STRODE AVENUE
COATESVILLE, PA, 19320
LICENSE/COC#: 10566

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2024, 04/16/2024 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HARRISON SENIOR LIVING OF COATESVILLE* **License #**: *10566* **License Expiration**: *02/22/2025*

Address: *300 STRODE AVENUE, COATESVILLE, PA 19320*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *HARRISON SENIOR LIVING OF COATESVILLE LLC*

Address: *300 STRODE AVENUE, COATESVILLE, PA, 19320*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/03/1986* **Issued By**: *COPA*

Staffing Hours

Resident Support Staff: *87* **Total Daily Staff**: *149* **Waking Staff**: *112*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/16/2024*

Inspection Dates and Department Representative

04/15/2024 - On-Site:

04/16/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *52*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

04/15/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/09/2024*

Inspections / Reviews *(continued)*

05/13/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/10/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *05/15/2024*

07/10/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/10/2024*
Reviewer: [redacted]
Follow-Up Type: *Bypass Document Submission*

07/10/2024 - Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *07/10/2024*
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 4/16/24, during the medication pass, Staff member A left the computer screen open with the resident's information visible and walked away to the resident's room to administer the medication.

Plan of Correction ***Accept (- 07/10/2024)***

ACTION OWNER COMPLETION DATE
1. 2600.17 Resident records shall be confidential.....
Immediately after incident occurred staff member was reminded to
minimize computer screen each time they are walking away and
administering to a medication by the Executive Director 4/16/2024
An Inservice will be conducted on Resident Confidential Records 2600.17 by Director of Resident Services by 4/29/2024
to all nursing staff that administer medications.
Spot checks to be done to monitor staff to ensure
compliance and record of spot checking will be kept in a binder
in the Director of Resident Services office by Assistant Director of Resident Services Monthly and by 5/1/2024
Oversite of monitoring of compliance record will be done quarterly and ongoing by Director of Resident Service.
Yearly inservicing of Residents Privacy are conducted by Director of Resident Services by 4/29/2024 and or designee and ongoing.

Licensee's Proposed Overall Completion Date: *06/18/2024*

Implemented (- 07/10/2024)

28f - Resident's Funds and 30-day Refund

2. Requirements

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident 1 moved out of the home on ; however, the refund check was not issued until .

Plan of Correction ***Accept (- 07/10/2024)***

This issue of 30-day refunds was observed when an audit was done by the office Manager in August of 2023. At this time a system was put into place to ensure compliance of the regulation. A spread sheet was developed that included the following: Residents discharge date, residents name, amount of refund, date check was issued and check number. Information for this spread sheet is given to the corporate controller by the office manager ongoing as discharges occur. An audit is conducted to ensure compliance by the office manager monthly that started 9/1/23. Quarterly audits are reviewed by the Executive Director that started on 10/1/23. Since this system was put into place in August 25 of 2023 there has not been any issues with out of compliance refunds.

28f - Resident's Funds and 30-day Refund *(continued)*

Licensee's Proposed Overall Completion Date: *07/05/2024*

Implemented (- 07/10/2024)

86b - Bathroom

3. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

The bathrooms in rooms 218 and 220, do not have an operable window or ventilation fan. The fan is inoperable and there is no window in the bathroom.

Plan of Correction ***Accept (- 07/10/2024)***

The bathroom ventilation fans for room 218 and room 220 was
replace with operable fans by Maintenance Director/ or designee by 5/24/2024
The Director of maintenance will do an audit of all the rooms to make
sure, the bathroom fans are operable by Maintenance Director/ or designee 6/1/2024
An additional audit of bathroom fans will be placed on the safety
audit sheet to be tested semiannually by the Maintenance Director and Ongoing. During safety meeting the audit will be checked to ensure compliance. Safety Meeting Committee meets monthly, and this audit will be reviewed at this time. Next audit for this report is 1/2/25 during Safety Meeting.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

141a 1-10 Medical Evaluation Information

5. Requirements

2600.
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

Each of the resident's records reviewed including resident #2's DME dated is missing the medical information pertinent to a diagnosis treatment.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction ***Accept (- 07/10/2024)***

The Medical Evaluation for resident #2 will be updated to state N/A
(Non-applicable) under information pertinent to a diagnosis
treatment after consulting with the resident's physician. Director of Resident Services 4/17/2024
A review of all current medical evaluations will be reviewed to ensure
to include information pertinent to a diagnosis treatment if applicable. Assistant Director of Resident Services 4/31/2024
The review will be in coordination with the attending physician.
N/A will be placed in this section if treatment is not applicable
Inservice with the Director of Admissions on the Medical Evaluation
requirements. Executive Director 5/1/2024
All new admissions will be reviewed to include information pertinent
to a diagnosis, see attached sheets, or N/A if not appliable. Director of Admissions / LPN Ongoing 5/1/2024
A medical evaluation audit sheet will be developed to ensure compliance Assistant Director of Nursing Monthly 5/1/2024
A yearly audit will be done to ensure compliance
Director of Resident Services or 1/2/2025 designee Yearly

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

181c - Self-administration Assessment

6. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #2 is marked as able to self-administer medications on the DME dated . However, it is marked as not being able to self-administer medications on the prescreen dated , and on the RASP dated

Plan of Correction ***Accept (- 07/10/2024)***

Note: Facility had documentation from the attending physician that resident #2 and able to self-medicate. The DME and RASP were correct dated February 2024. Order for self-medication administration was attached to the RASP at the time of inspection. Staff failed to update RASP at time of the order
All resident assessments (RASP) will be updated at the time of the order to self-medicate by the nursing staff and the DORS ongoing. An in-service will be provided to all nursing staff on updating residents' assessments at the time of the change on the event tracking form for the RASP for all nursing staff and med techs that handle the RASP. (5/1/24) An audit will be conducted to ensure compliance by developing a check list audit form by the ADORS by 6/2/24 and monthly. Oversite of compliance by the DORS by 7/1/24 and quarterly.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

183e - Storing Medications

7. 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

Lorazepam Tab 1 mg, prescribed for Resident #3 was in a blister card. The foil on the back of blister spot #21 had been torn and taped.

Resident #4 has an order for Lorazepam 0.5 tab, take one by mouth every 12 hours as needed for anxiety. The residents medication blister package indicates the medication expired on 3/27/24. The blister package was present on the medication cart on 4/16/24

Resident #5's has an order for Timolol eye drops. The manufacturers instructions indicate to use medication within the expiry date shown on the bottle AND within 4 weeks of opening. On 4/16/24, the residents medication bottle had an opened on date of 3/3/2024.

Lacosamide Tab 200 mg, prescribed for Resident #3 was in a blister card. The foil on the back of blister spot #6 was punctured and the medication was still present in the blister.

Plan of Correction ***Accept (- 07/10/2024)***

Any medications found that were torn or taped were send back to the
pharmacy to be repackaged. LPN on Duty Immediately / 4/16/2024. Medication that was expired was removed from the medication cart.
All nurses and med techs were re-Inservice on Medication storage Policy by Director of Resident Services 5/15/2024
Audits will be done by the nursing Services Assistant Director of Resident Monthly / 6/2/2024
Audits to monitor will be done to ensure compliance. Director of Resident Services Quarterly 6/17/2024

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

185a - Implement Storage Procedures

8. 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

Lacosamide Tab 200 mg, prescribed for Resident #3, has a count on the narcotics declining inventory log form of 39; however, the actual count on the blister pack was 38.

On , Resident #3 had a change in prescription for Ativan/Lorazepam PRN from 1mg as needed to 0.5 mg one by mouth every 12 hours as needed. The facility did not obtain a new package of medication with the correct dose, and is instead using the 1mg-tablet prescription blister pack. The home is cutting the 1mg pill in half and keeping the other half in the blister package to use it at a later time.

185a - Implement Storage Procedures (continued)

Resident #6 is prescribed Hydrocort Cream 2.5%- apply topically to rash twice a day as needed; however, on 4/16/24 the medication was not available on the medication cart.

Plan of Correction ***Accept (- 07/10/2024)***

Note: The medication for resident #3 was signed out on the MAR but staff failed to sign medication out on the narcotics log sheet at the time of the administration.
Staff signed medication out on the narcotic log sheet by LPN on duty immdiately on 4/16/24. Medication for resident #6 - staff obtained order from attending Physician to discontinue order by SPN on duty immediately on 4/16/24. Medication for resident #3 was sent back to pharmacy to repackage the .5 mg dose. by LPN on duty immediately on 4/16/24. All nursing staff that handle medication will be re-inserviced on implement storage Procedures and Medication Accountability and Substances and Narcotic Accountability by DORS by 4/29/24. An audit sheet will be developed to track audits being done by DORS by 5/1/24. Audits will be conducted to ensure compliance for Medication Storage Procedure, Medication Accountability and Controlled Substances and Narcotic Accountability by the ADORS by 5/1/24 and monthly. Monitoring of audits will be done quarterly and be reviewed at the Quarterly Quality Assurance Meetings by the DORS by 6/17/24 and quarterly.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

187b - Date/Time of Medication Admin.

9. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Lacosamide Tab 200 mg, prescribed for Resident #3, was administered on the morning by a staff member, but the medication was not initialed or signed off on the narcotic log at the time that the medication was administered.

Plan of Correction ***Accept (- 07/10/2024)***

Note: The medication for resident #3 was signed out on the MAR but staff failed to sign medication out on the narcotics log sheet at time of the administration.
Staff signed medication out on the narcotic long immediately on 4/15/24 by the LPN on duty. All nursing staff that handle medications will be re-inserviced on Date/Time of Medication Administration by the DORS by 4/29/24. At each shift change the class two narcotics are counted and signed for accuracy in the shift change sheet count by two staff persons by LPNs and Med Techs each shift and daily. Audits will be conducted to ensure compliance for Time/Date of Medication Administration in the Narcotic Logbook by ADORS by 5/1/24 and monthly. Monitoring of audits will be done quarterly and be reviewed the Quarterly Quality Assurance Meetings by the DORS by 6/17/24.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (- 07/10/2024)

225a - Assessment 15 Days

10. 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.

225a - Assessment 15 Days *(continued)*

Description of Violation

Resident #7's date of admission was [redacted]; however, [redacted] initial assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 07/10/2024)***

Each written assessment will be completed within 15 days of admission.
Assistant Director of Resident Services / Ongoing

An audit was completed to ensure all current resident's assessment
were completed within 15 days of admission.
All other residents' assessments met requirements
Director of Resident Services 4/18/2024

An Audit sheet will be developed to track audits being done.
Director of Resident Services
5/29/2024

Audits will be conducted to ensure compliance for Assessments
being completed within 15 days of admission
Assistant Director of Resident Services
Monthly
6/1/2024

Monitoring of audits will be done quarterly and be reviewed at
the Quarterly Quality Assurance Meetings.
Director of Resident Services
Quarterly / 6/17/2024

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented ([redacted] - 07/10/2024)

227d - Support Plan Medical/Dental

11. 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

Resident #2's RASP dated [redacted] indicates that the resident has a need related to agitation but the residents support plan it does indicate the description of need or the plan to meet the residents need.

Resident #8's medical evaluation dated [redacted] specifies that the resident has a diet of no concentrated sweets;

227d - Support Plan Medical/Dental (continued)

however, this diet is not on the RASP dated 2/21/2024.

Plan of Correction ***Accept (█ - 07/10/2024)***

Note: Face Sheet was correct, MAR was correct, Dining Diet List was Correct. Medical Evaluation was correct. RASP indicated incorrect diet. Resident #2 RASP was check in error.
The Support Plan for resident #8 was updated by Director of Resident Services immediately on 4/16/24. The support plan for resident #2 was updated immediately on 4/16/24.
An Audit was completed to ensure all current resident's RASP diets were correct by DORS by 4/20/24. An audit sheet will be developed to track audits being done by DORS by 4/20/24. Audits will be conducted to ensure compliance for Assessments being completed within 15 days of admission by ADORS by 6/1/24 and monthly. Monitoring of audits will be done quarterly and be reviewed at the Quarterly Quality Assurance Meeting by DORS by 6/17/24 and quarterly.

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented (█ - 07/10/2024)

252 - Record Content

12. Requirements

2600.

252. Content of Resident Records - Each resident’s record must include the following information:
    1. Name, gender, admission date, birth date and Social Security number.
    2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
    3. A photograph of the resident that is no more than 2 years old.
    4. Language or means of communication spoken or used by the resident.
    5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
    6. The name, address and telephone number of the resident’s physician or source of health care.
    7. The current and previous 2 years’ physician’s examination reports, including copies of the medical evaluation forms.
    8. A list of prescribed medications, OTC medications and CAM.
    9. Dietary restrictions.
    10. A record of incident reports for the individual resident.
    11. A list of allergies.
    12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
    13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
    14. A support plan.
    15. Applicable court order, if any.
    16. The resident’s medical insurance information.
    17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
    18. An inventory of the resident’s personal property as voluntarily declared by the resident upon admission and voluntarily updated.
    19. An inventory of the resident’s property entrusted to the administrator for safekeeping.
    20. The financial records of residents receiving assistance with financial management.
    21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
    22. Copies of transfer and discharge summaries from hospitals, if available.
    23. If the resident dies in the home, a copy of the official death certificate.

252 - Record Content *(continued)*

24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident #7 was involved in an incident with another resident on [redacted]. However, there is no copy of the incident report in the resident #7's record.

Plan of Correction ***Accept ([redacted] - 07/10/2024)***

Resident #7 incident report was placed in residents' records on the
nursing floor. Immediately by Director of Resident Services 4/16/2024
Resident incident Reports will remain in a binder, but a copy will be
placed in each resident record. Assistant Director of Resident Services 4/16/2024
An audit was completed to ensure all residents that have an incident
report is part of the resident's record on the nursing floor. Assistant Director of Resident Services 4/30/2024
Audits will be conducted to ensure compliance
Check list audit form to be used. Assistant Director of Resident Services. Monthly 5/1/2024
Monitoring will be done to ensure compliance by the Director of Resident Services and
during the Quality Assurance Meetings starting 6/17/2024

Licensee's Proposed Overall Completion Date: *07/08/2024*

Implemented ([redacted] - 07/10/2024)