pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **JENNER'S POND INC**
LEGAL ENTITY

To operate **RUSTON RESIDENCE**
NAME OF FACILITY OR AGENCY

Located at **100 SYCAMORE DRIVE, WEST GROVE, PA 19390**
(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 **Assisted Living-Special Care**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **70** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Special Care Unit - 55 Pa.Code §§ 2800.231-239 - Capacity 12**

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

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **October 8,** **2024** until **April 8,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **138891**

ISSUING OFFICER

Juliet Marsala
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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 8, 2024

[redacted]
Jenner's Pond, Inc.
[redacted]

RE: Ruston Residence
100 Sycamore Drive
West Grove, Pennsylvania 19390
License #: 138891

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection March 6 and 7, 2024 and May 6, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance 138990 dated July 4, 2024 to July 4, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated July 4, 2024 to July 4, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 8, 2024 to April 8, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

[redacted]

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 30 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
[redacted]

This decision is final 31 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *RUSTON RESIDENCE* **License #:** *13889* **License Expiration:** *07/04/2024*

Address: *100 SYCAMORE DRIVE, WEST GROVE, PA 19390*

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

Administrator

Name: [redacted]

Legal Entity

Name: *JENNER'S POND INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/06/1998* **Issued By:** *Commonwealth of PA, L & I*

Staffing Hours

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

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *03/07/2024*

Inspection Dates and Department Representative

03/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served:** *48*

Special Care Unit

In Home: *Yes* **Area:** *Lavender Lane* **Capacity:** *12* **Residents Served:** *12*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *48*
Diagnosed with Mental Illness: *24*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30*
Have Physical Disability: *0*

Inspections / Reviews

03/06/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/02/2024*

04/15/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/25/2024*

07/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

17 Record confidentiality

1. Requirements

2800.

17. Confidentiality of Records - 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 3/6/2024, the nurse's office in the memory care unit with the residents' charts was unlocked, unattended, and accessible to everyone.

On 3/6/2024, in the memory care unit, there was a narcotics book, a table with each shift's assignment binder, and the residents' vitals and weight binder on top of the medication cart, unlocked, unattended, and accessible to everyone in the home.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/6/2024, the Nurse Manager secured the nurses office, narcotics book, assignment binder, and weights and vitals binder.

• On 3/6/2024, the Nurse Manager audited the common areas of the community to ensure confidential records, weights, were secured.

• On 3/28/2024, the Regional Director of Clinical Services (RDCS) and Nurse Manager began in-servicing direct care staff on the requirements set within regulation 2800.17. (Exhibit A1 – In-service)

• Beginning 4/1/2024, the Nurse Manager or designee will audit the common areas weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit A2 – Audit tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 07/31/2024)

28e Refund - death

2. Requirements

2800.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the residence shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The residence shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on [redacted]/2023. Resident #1's personal belongings were removed from [redacted] room on [redacted] The resident was [redacted] and the residence did not provide a refund in accordance with the Elder Care Payment Restitution Act (35 P.S. § § 10226.101—10226.107). Residence sent the refund check on [redacted]

28e Refund - death (continued)

Resident #2 passed away on [redacted]/2023. Resident #2's personal belongings were removed from [redacted] room on [redacted] The resident was [redacted] and the residence did not provide a refund in accordance with the Elder Care Payment Restitution Act (35 P.S. § § 10226.101—10226.107). Residence sent the refund check on 2/21/2024.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• The community is unable to correct this deficient practice for Resident #1 and Resident #2.

• On 4/1/2024, the Admissions Director audited resident refunds within the past year to self-identify additional deficient practices. For instances identified, the Administrator will reviewfor potential trends and conduct root cause analysis contributing to the delayed refund.

• Beginning 4/1/2024, the Administrator or designee will audit the refund statuses belonging to recently discharged residents weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit B1-Audit Tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted]/31/2024)

51 Criminal background checks

3. Requirements

2800.

51. Criminal background checks
    a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
    b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

On 3/06/2024 and 03/07/2024, renovations were performed at the facility by a construction company in the residents common areas. However, none of the construction workers had criminal background checks.

Plan of Correction Repeat Violation: 12/28/22. ***Accept [redacted] - 04/15/2024)***

• On 4/2/2024, the Administrator educated the Maintenance Director and on the requirements set within 2800.51. (Exhibit B1 – In-service)

• By 4/1/2024, the contractors conducting renovations within the community completed criminal background checks in accordance with 2800.51. (Exhibit B2 – Background checks)

• Beginning 4/1/2024, the Maintenance Director will audit the completion of contractor background checks weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit B3 – Audit tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

51 Criminal background checks *(continued)*

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

)

81b Resident equip – good repair

5. Requirements

2800.
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 #3 has an enabler with measurements of 38" high and 14" wide. However, the enabler is not attached to the bed frame and is 7" inches apart from the mattress.

Repeat Violation - 8/17/2023 et al

Plan of Correction ***Accept [redacted] 04/15/2024)***

• On 3/20/2024, the Maintenance Director ensured that Resident #3s bed enabler was secured to the bed frame and less than 4 ½" from the mattress.
• On 3/20/2024, the Administrator ensured that current resident beds fitted with a bed enabler were securely attached to the bed frame and less than 4 ½" from the mattress.
• Beginning 4/1/2024, the Administrator or designee will audit Resident rooms with bed mobility devices to ensure

81b Resident equip – good repair (continued)

they are securely fastened to the bed frame weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1 to validate sustained compliance. (Exhibit D1 – Audit tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

91 Telephone Numbers

6. Requirements

2800.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and assisted living residence 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 bedrooms [redacted].

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/20/2024, the Administrator provided Resident's occupying apartments #[redacted] with a list of emergency phone numbers within eyesight of their telephone.

• On 3/20/2024, the Administrator audited resident apartments to ensure that no additional apartments were missing emergency phone numbers listed near resident phones. No additional instances were identified.

• Beginning 4/1/2024, the Administrator or designee will audit three resident apartment telephones for posted emergency phone numbers weekly x four weeks, then, bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit E1 – Audit Tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

101j1 Bed/Fire retardant mattress

7. Requirements

2800.

101.j. Each resident shall have the following in the living unit:

1. A bed with a solid foundation and fire retardant mattress that is in good repair, clean and supports the resident. An exception will be permitted for residents who wish to provide their own mattresses.

Description of Violation

The base of resident #3's bed is unstable. There are two beds next to each other that could represent entrapment because they are not connected.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/20/2024, the Administrator and Nursing staff separated the two mattresses.

• On 3/20/2024, the Administrator inspected currently occupied resident apartments to ensure beds were not

101j1 Bed/Fire retardant mattress (continued)

pushed together. No additional instances were identified.

• Beginning 4/1/2024, the Administrator or designee will audit occupied resident apartments weekly x 4 weeks, then bi-weekly x 4 weeks, and then monthly x 1, to validate sustained compliance (Exhibit F1 – Audit Tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] 07/31/2024)

101j7 Lighting/operable lamp

8. Requirements

2800.
101.j. Each resident shall have the following in the living unit:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #4 does not have access to a source of light that can be turned on/off at bedside.

Repeat Violation - 8/17/2023 et al. 12/28/22.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/20/2024, the Administrator provided Resident#4 a working bedside lamp and placed it within reach of the bed.

• On 3/20/2024, the Administrator audited resident apartments to ensure each had a bedside light source within reach. No additional instances were noted.

• Beginning 4/1/2024, the Administrator or designee will audit three resident apartments weekly x four weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit G1- Audit Tool)

• Results of the audit will be discussed during quarterly QAPI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

103f Fridge/Freezer Temps

9. Requirements

2800.
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 3/7/2024, at 11:17 a.m., the temperature in the Memory Care Unit refrigerator freezer was 12 degrees Fahrenheit.
On 3/7/2024, at 11:36 a.m., the temperature in the ice cream freezer was 10 degrees Fahrenheit.

103f Fridge/Freezer Temps *(continued)*

Plan of Correction ***Accept (- 04/15/2024)***

• On 3/8/2024, facility maintenance staff serviced the freezer in the Lavendar Lane memory care unit to ensure temperatures remained below 0 degrees F.
• On 3/8/2024, facility maintenance staff serviced the ice cream freezer to ensure temperatures remained below 0 degrees F.
• On 3/9/2024, the Administrator audited Ruston freezers to ensure temperatures remained below 0 degrees F to validate compliance.
• Beginning 4/1/2024, the Administrator or designee will audit 3 of the facilities freezers weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit H1 – Audit Tool)
• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented - 07/31/2024)

107a Emergency preparedness

10. Requirements

2800.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the residence is located.

Description of Violation

Staff person A, the is not familiar with, and does not have, a copy of the emergency preparedness plan for the local municipality in which the residence is located.

Plan of Correction ***Accept - 04/15/2024)***

• On 3/20/2024, the Maintenance Manager requested the emergency preparedness plan from the local municipality in which the resident is located.
• As of 4/2/2024, the Administrator is in receipt of the emergency preparedness plan. (Exhibit I1 – Plan)
• On 4/2/2024, the Administrator in-serviced the community leadership on the plan and where it is kept within the community. (Exhibit I2 – In-service)

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented - 07/31/2024)

107b Emergency procedures

11. Requirements

2800.
107.b. The residence shall have written emergency procedures that include the following:
1. Contact information for each resident's designated person.
2. The residence's plan to provide the emergency medical information for each resident that ensures confidentiality.

107b Emergency procedures *(continued)*

3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The residence's written emergency procedures reviewed on 8/30/2023 do not include the contact telephone numbers of local and state emergency management agencies and local resources for housing and emergency care of residents.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 4/2/2024, the Maintenance Director updated the residence's written emergency procedures to include phone numbers for local and state emergency management agencies and local resources for house and emergency care of residents. (Exhibit J1 – Updated plan)

• On 4/1/2024, the Administrator created and sent a Microsoft Outlook calendar reminder and invite to Administration, to prompt the 2025 annual review and revision of community's emergency procedures.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented ([redacted]/31/2024)

107d Procedure EMA submission

12. Requirements

2800.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The residence's written emergency procedures have not been reviewed, updated, and submitted annually to the local emergency management agency.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 4/2/2024, the Administration and Director or Maintenance reviewed, updated, and submitted the Emergency Procedures to the local emergency management agency.

• On 4/1/2024, the Administrator created and sent a Microsoft Outlook calendar reminder and invite to Administration, to prompt the 2025 annual review and submission of the community's emergency procedures to the local emergency management agency.

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented [redacted] - 07/31/2024)

124 Notice to fire department

13. Requirements

124 Notice to fire department *(continued)*

2800.
124. The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

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

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 4/2/2024, the Maintenance Director notified the local fire department via email of the facility's address, location of the living units and bedrooms, and the needed assistance to evacuate in the event of an emergency. (Exhibit K1 – Email)

Licensee's Proposed Overall Completion Date: *04/02/2024*

Implemented ([redacted] - 07/31/2024)

132f Alternate exit routes

14. Requirements

2800.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The main rose exit was the only exit route used during the fire drills held from November 2023 to February 2024.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/28/2024, the Administrator educated the Maintenance Director on the requirements set within 2800.132.f.
• Between the dates of 4/1/2024 and 6/30/2024, the Maintenance Director will conduct unannounced fire drills, one drill on each shift, in various locations of the community which required a different exit route for each drill, other than the main rose exit. (Exhibit L1 – Drill Reports)
• Beginning 4/1/2024, the Administrator will audit the fire drill documentation monthly x 3 months to ensure an alternative exit route was used during each drill, in accordance with 2800.132.f. (Exhibit L2 – Audit tool)

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

162c Menus - posted

15. Requirements

2800.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The residence's menu for February 11 to February 24 was posted. However, the current menu for March 3rd to March 9th and the following week was not posted in a public and conspicuous place in the memory care unit.

162c Menus - posted *(continued)*

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/12/2024, the Menu was replaced with the current week and the following week.

• On 3/12/2025, the Dining Director audited posted menus to ensure compliance with regulation 162c. All menus were up to date.

• Beginning 4/1/2024, the Dining Director or designee will audit the posted menus weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit M1 – Audit Tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

171b5 Transportation-first aid kit

16. Requirements

2800.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2800.96 (relating to first aid kit). The inclusion of an automatic external defibrillation device in a vehicle is optional.

Description of Violation

The first aid kit in the bus used to transport residents does not include an eye covering or thermometer.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/18/2024 the Administrator placed a thermometer and goggles within the first aid kit located on the bus.

• Beginning 4/1/2024, the Administrator or designee will audit the contents of the busses first aid kit weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit N1 – Audit tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

182c Medication administration

17. Requirements

2800.
182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.
6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
7. Complete documentation in accordance with § 2800.187 (relating to medication records).

[redacted]

183e Storing Medications

18. Requirements

2800.
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

On 3/7/2024, there was one loose pill in the Laurel Way cart. According to the manufacturer's instructions, this is not a safe way to store medications in an organized manner under proper conditions of sanitation, temperature, moisture, and light.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/7/2024, the Nurse Manager discarded the pill per community policy.

• On 3/7/2024, the Nurse Manager audited the community's medication carts for loose pills. No additional loose pills were noted.

• On 3/25/2024, the RDCS and Nurse Manager began in-servicing the home's licensed nurses and medication technicians on the requirements set within 2800.183.e. (Exhibit P1 – In-service)

• Beginning 4/1/2024, the Nurse Manager or designee will audit the homes medication carts weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit P2 – Audit tool)

183e Storing Medications (continued)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 07/31/2024)

184a Resident meds labeled

21. Requirements

2800.

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.

184a Resident meds labeled *(continued)*

Description of Violation

Resident #13 is prescribed Lorazepam 0.5 mg PRN every six hours and at bedtime, but the blister pack present was for PRN only.

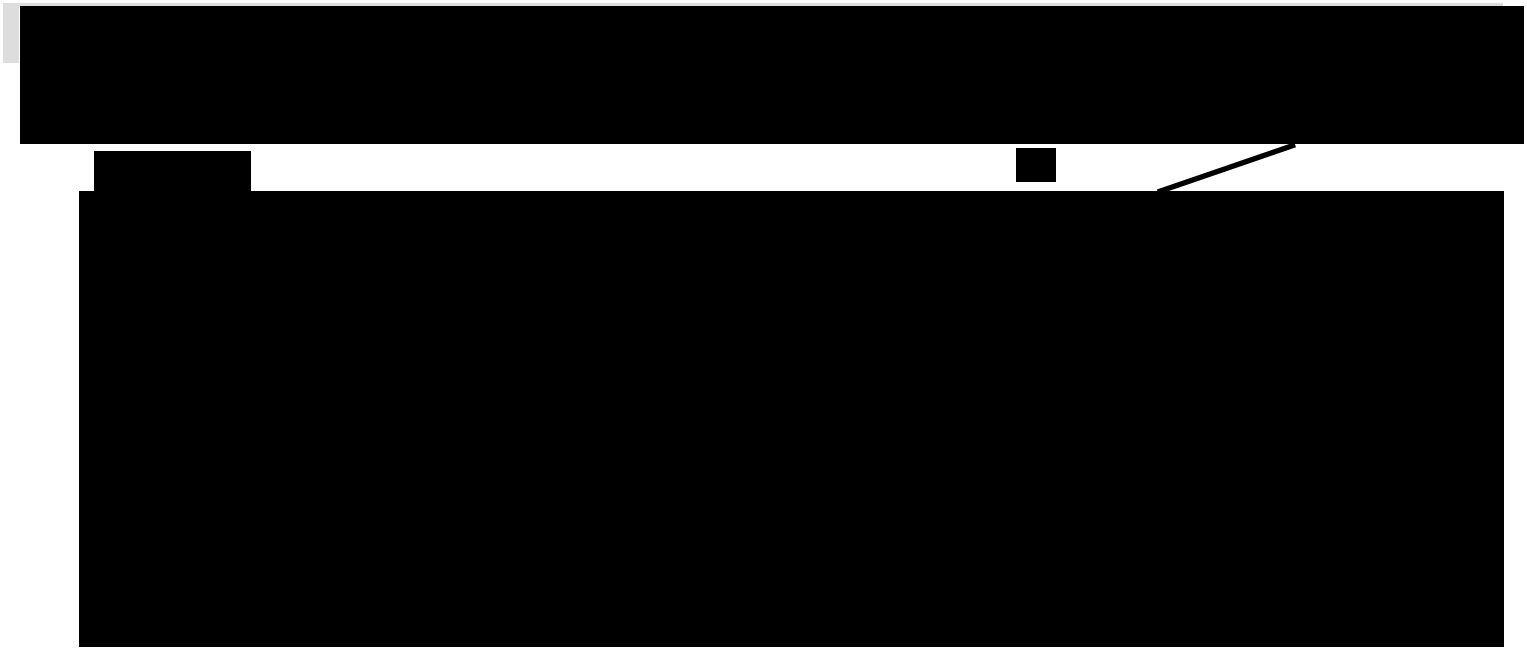
Resident #14 is prescribed Lorazepam 0.5 mg 3 times a day as needed and once in the morning, but the pharmacy label reads every 4 hours as needed.

Plan of Correction ***Accept [redacted] 04/15/2024)***

• On 3/7/2024, the Nurse Manager placed a "Directions Changed/See MAR" sticker adjacent to Resident #7's Acetaminophen 500mg prescription label.
• On 3/7/2024, the Nurse Manager placed a "Directions Changed/See MAR" sticker adjacent to Resident #13's Lorazepam 0.5mg prescription label.
• On 3/7/2024, the Nurse Manager placed a "Directions Changed/See MAR" sticker adjacent to Resident #14's Lorazepam 0.5mg prescription label.
• On 3/26/2024, the RDCS audited controlled medication prescription labels within the home and for instances where the instructions indicated on the label do not match one or more resident prescription orders, placing "Directions Changed/See MAR" sticker adjacent to the label(s) as needed.
• On 3/8/2024, the Regional Director of Clinical Serviced (RDCS) educated the Pharmacy Director to include a "Directions Changed/See MAR" sticker on medication labels for medications that have two or more directions for use.
• Beginning 4/1/2024, the Nurse Manager or designee will audit 3 controlled medication prescription labels weekly x 4 weeks, the bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit S1 – Audit tool).
• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Not Implemented ([redacted] 07/31/2024)

[redacted]



186b

23. Requirements

2800.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 2/11/2024, resident # 6 was administered medication prescribed for and belonging to resident # 5.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 2/11/2024, the agency staff member self-reported the error to community leadership.
• On 2/12/2024, the community self-reported the incident to the Department.
• On 2/11/2024, a licensed nurse reported the medication error to the resident, resident's responsible party, and their primary care physician.
• On 2/11/2024, Resident #6 was evaluated by a licensed nurse.
• On 2/12/2024, Resident #6 was assessed by a Nurse Practitioner.
• As of 2/12/2024, the agency staff member who made the error was no longer employed by the community.
• On 2/12/2024, Resident #5's replacement medications were ordered from the pharmacy and expensed to the community.
• Beginning 4/3/2024, the RDCS and Nurse Manager began in-servicing licensed nurses and medication technicians on the five rights of medication administration. (Exhibit U1 – In-Service)
• Beginning 4/1/2024, the Nurse Manager or designee will randomly observe a licensed nurse or medication technician administer resident medications, weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate that the five rights of medication administration are followed. (Exhibit U2 – Competency Audit)
• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 07/31/2024)

186b Medication used by resident *(continued)*

187d Follow prescriber's orders

25. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #15 is prescribed insulin based on the prescribed sliding scale. However, resident #15 was administered the wrong dose of insulin due to the wrong numbers on 3/07/2024 at 11:57 a.m. reading on the glucometer was 340 but logged as 255; resident 15 was given 6 units instead of 8 units. On 3/04/2024 at 12:35 p.m., the reading on the glucometer was 275, requiring 6 units, but logged as 189 and given 2 units. On 3/03/2024 at 1:34 p.m., the reading on the glucometer was 345 but logged as 235, giving 4 units instead of 8 units.

Plan of Correction ***Directed ([redacted] 04/15/2024)***

• On 3/7/2024, the Nurse Manager notified Resident #15 of the discrepancies pertaining to their glucometer readings on 3/3/24, 3/4/24, and 3/7/24, and their documented units of administered units of insulin on those dates.
• On 3/7/2024, the Nurse Manager notified Resident #15's medical provider of the discrepancies pertaining to their glucometer readings on 3/3/24, 3/4/24, and 3/7/24, and their documented units of administered insulin on those dates.
• On 3/8/2024, the RDCS calibrated the glucometers to the correct dates and times.

187d Follow prescriber's orders (continued)

• Beginning 4/1/2024, the Nurse Manager or designee will audit 3 the glucometer readings and associated MAR entries weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 month to validate sustained compliance. (Exhibit W1 – Audit Tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Proposed Overall Completion Date 4/30/24
Directed Plan of Correction (slw 4/15/24):
In addition to the POC steps noted above the administrator will ensure all staff administering medications will be retrained on Glucometers and medication administration documentation plus following physician orders.

Directed Completion Date: *04/30/2024*

Not Implemented [redacted] 07/31/2024)

227d Support plan – med/dental

26. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Description of Violation

On 09/08/2023 resident #3 uses a bed enabler for repositioning. However, the resident's support plan, dated 3/10/2023, does not specify the intent to use, any risk associated with the device, the resident's ability to use the device safely for the intended purpose, or the identification of the device.

Plan of Correction ***Accept [redacted] 04/15/2024)***

• On 3/11/2024, the Nurse Manager removed the bed enabler, as the resident no longer required its use.

• On 4/1/2024, the RDCS audited the ASPs of current residents who utilize bed enablers, in attempt to identify documentation omissions relative to bed enabler use. For omissions noted, the RDCS or Nurse Manager updated the ASP accordingly. (Exhibit X1– Audit tool)

• Beginning 4/1/2024, the Nurse Manager or designee will audit the ASPs of current residents who utilize a bed enabler weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit X2 – Audit tool)

• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented (MS - 07/31/2024)

233c Key-locking devices

27. Requirements

2800.
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 residence's locking mechanism are not conspicuously posted near the exit door in the special care unit.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• On 3/12/2024, the Administrator conspicuously posted the code to the memory care exit door.
• On 3/20/2024, the Administrator audited locked doors in the Memory Care unit. No additional instances of missing codes were noted. (Exhibit Y1- Audit Tool)
• Beginning 4/1/2024, the Administrator or designee will audit the memory care locked doors to ensure they have a visible exit code weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit Y2 – Audit Tool)
• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/31/2024)

236a Staff training

28. Requirements

2800.
236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person B (date of hire: [redacted]) works in the special care unit but only completed 4 hours of initial training related to dementia care within the first 30 days of the date of hire.

Direct care staff person C (date of hire: [redacted] works in the special care unit but only completed 4 hours of initial training related to dementia care within the first 30 days of the date of hire.

Plan of Correction ***Accept [redacted] - 04/15/2024)***

• Direct care staff person B and direct care staff person C are employed by a staffing agency.
By 4/7/2024, the RDCS, in collaboration with the agency leadership will have ensured adequate dementia care trainings are provided to agency staff moving forward.
• Beginning 4/1/2024, the Administrator will audit 3 newly hired agency employees training records weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 to validate sustained compliance. (Exhibit Z1 – Audit tool)
• Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 07/31/2024)

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

Facility Information

Name: *RUSTON RESIDENCE* **License #:** *13889* **License Expiration:** *07/04/2024*

Address: *100 SYCAMORE DRIVE, WEST GROVE, PA 19390*

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

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *JENNER'S POND INC*

Address: [redacted]

Phone: [redacted] **Email:** [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *04/06/1998* **Issued By:** *COPA*

Staffing Hours

Resident Support Staff: *78* **Total Daily Staff:** *151* **Waking Staff:** *113*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date:** *05/06/2024*

Inspection Dates and Department Representative

05/06/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served:** *43*

Special Care Unit

In Home: *Yes* **Area:** *Lavender Lane* **Capacity:** *12* **Residents Served:** *11*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *43*
Diagnosed with Mental Illness: *24*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *30*
Have Physical Disability: *0*

Inspections / Reviews

05/06/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/01/2024*

06/03/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/28/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/01/2024*

07/31/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/28/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

17 Record confidentiality

1. Requirements

2800.
17. Confidentiality of Records - 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 5/6/24 at 1:15pm, the medication room in the Special Care Unit (SCU) was unlocked, unattended, and accessible to the SCU residents/visitors. In the medication room, a narcotics log and resident records were left out, and the medication refrigerator was also unlocked.

Plan of Correction ***Accept [redacted] 06/03/2024)***

- On 5/6/2024, the ALA secured the nurses office, medication refrigerator, narcotics book, assignment binder and weights and vitals binder
- On 5/6/2024, the Nurse Manager audited the common areas of the community to ensure confidential records, weights, refrigerators were secured.
- On 5/29/2024, the ALA and Nurse Manager began in-servicing direct care staff on the requirements set within regulation 2800.17 (Exhibit A1-In-service)
- Beginning 6/1/2024, the Nurse Manager or designee will audit the common areas weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1 to validate sustained compliance (Exhibit A2-Audit tool).
- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] - 07/31/2024)

183c Refrigerated meds locked

2. Requirements

2800.
183.c. Prescription medications, OTC medications and CAM stored in a refrigerator shall be kept in an area or container that is locked unless the resident has the capacity to store the medications in the resident's own refrigerator in the resident's living unit.

Description of Violation

On 5/6/24, at 1:15pm, the refrigerator in the medication room of the SCU was unlocked and accessible to residents/visitors.

Plan of Correction ***Accept [redacted] - 06/03/2024)***

- On 5/6/2024, the ALA secured the refrigerator and the med room of the SDCU
- On 5/6/2024, the ALA audited the rooms and common areas of the SDCU to ensure no meds had been removed from the refrigerator.
On 5/29/2024, the ALA and Nurse Manager began in-servicing the homes licensed nurses and medication technicians on the requirements set within 183c (Exhibit B1 - Inservice)
- Beginning 6/1/2024, the Nurse Manager or designee will audit the common areas weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1 to validate sustained compliance (Exhibit A2-Audit tool).

183c Refrigerated meds locked (continued)

- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] 07/31/2024)

184a Resident meds labeled

4. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for resident #7's bottle of Lorazepam 0.5mg tablet indicates administration every four hours as needed. It does not include a change of direction order. The physician's order sheet indicates three times a day as needed, as of 4/28/24.

Resident #7 has an additional bottle of Lorazepam 0.5 tablet every 4 hours. The physician's order sheet indicates to administer daily in the morning, as of 10/5/22. No change order is indicated.

Plan of Correction ***Accept [redacted] 06/03/2024)***

- On 5/6/2024, the Nurse Manager placed a "Directions Changed/ See MAR" sticker adjacent to Resident #7's Lorazepam 0.5 prescription label.
- On 5/20/2024, the Nurse Manager audited controlled medication prescription labels within the home and for instances where the instructions indicated on the label do not match one or more resident prescription orders, placing "Directions Changed/ See MAR" sticker adjacent to the label(s) as needed.
- Starting 5/29/2024, the ALA and Nurse Manager began in servicing the communities licensed nurses and medication technicians on the requirements set within regulation 184a. (Exhibit D1 - Inservice)
- Beginning 6/2/2024, the Nurse Manager or designee will audit 3 controlled medication prescription labels weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1 to validate sustained compliance (Exhibit D2- Audit Tool)
- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented ([redacted] 07/31/2024)

187c Refusal to take medication

5. Requirements

187c Refusal to take medication *(continued)*

2800.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

On 4/17/24, 4/18/24, 4/20/24, 4/21/24, 4/22/24, 4/24/24, 4/26/24, 4/27/24, 4/28/24 and 5/2/24, resident #6 refused to take their scheduled doses of Erythromycin. Resident #6 is prescribed 5mg Erythromycin via eye, three times per day. There is no documentation that the physician was notified of the resident's refusal.

Plan of Correction ***Accept [redacted] 06/03/2024)***

- On 5/6/2024, the Nurse Manager notified the Physician of Resident #6's refusal to take 5mg of prescribed 5mg Erythromycin on April 17, 18, 20, 21, 22, 24, 26, 27,28 and May 2, 2024.
- On 5/6/2024, the Nurse Manager audited Resident #6 MAR to ensure no additional refusal of medications had not been documented.
- On 5/29/2024, the Nurse Manager began in servicing licensed nurses and Medication Technicians on documenting refusals to take prescribed medications and notifying the physician. (See Exhibit E1- Inservice)
- Starting 6/1/2024, the Nurse Manager or designee will audit the eTAR weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance (Exhibit E2 - Audit Tool)
- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] 07/31/2024)

187d Follow prescriber's orders

6. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 is prescribed monthly weights and vitals on the 1st of each month. There is no documentation on the MAR that resident #3's vitals were taken on the 1st of May, 2024.

Plan of Correction ***Accept [redacted] 06/03/2024)***

- On 5/6/2024, the Nurse Manager obtained the vitals and weights of Resident #3 and documented on the MAR.
- On 5/6/2024, the Nurse Manager inspected all MAR's to ensure compliance with weights and vitals monitoring.
- On 5/29/2024, the ALA and Nurse Manager began in servicing licensed nursing staff and medication technicians on the regulations set in regulation 187d (Exhibit F1 - Inservice Tool)
- Starting 6/2/2024, the Nurse Manager or designee will audit the MAR's to ensure weights and vitals are entered per the prescribed order weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance. (Exhibit F2- Audit Tool).
- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued

187d Follow prescriber's orders (continued)

auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented [redacted] 07/31/2024)

227g Support plan - signatures

7. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #4 participated in the development of [redacted] support plan on [redacted] However, the resident did not sign or date the support plan.

Resident #8 participated in the development of [redacted] support plan on [redacted] However, the resident did not date the support plan.

Resident #9 participated in the development of [redacted] support plan on [redacted] However, the resident did not date the support plan.

Resident #10 participated in the development of [redacted] support plan on [redacted] However, the resident did not date the support plan.

Plan of Correction ***Accept ([redacted] 06/03/2024)***

-On 5/6/2024 the Nurse Manager obtained a late entry signature for Resident #4, #8, #9, #10 for their support plan
- Starting 6/2/2024, the Nurse Manager will audit the current support plans to ensure compliance with regulation 227g.
- On 5/29/2024, the ALA and Nurse Manager began in servicing licensed nursing staff and medication technicians on the regulations 227g. (See Exhibit G1- Inservice)
- Starting 6/2/2024, the Nurse Manager or designee will audit 3 different ASP's weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 1 month to validate sustained compliance (Exhibit G2- Inservice tool).
- Results of the audit will be discussed during quarterly QI meetings, The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented ([redacted] 07/31/2024)

236a Staff training

8. Requirements

2800.

236a Staff training *(continued)*

236.a. Each direct care staff person working in a special care unit for residents with Alzheimer's disease or dementia shall have 8 hours of initial training within the first 30 days of the date of hire and a minimum of 8 hours of annual training related to dementia care and services, in addition to the 16 hours of annual training specified in § 2800.65 (relating to staff orientation and direct care staff person training and orientation).

Description of Violation

Direct care staff person A, date of hire [redacted] works in the special care unit, but completed 0 hours of initial training related to dementia care within the first 30 days of the date of hire.

Plan of Correction ***Accept [redacted] - 06/03/2024)***

-On 5/6/2024, ALA notified HR of Direct Care staff person A not having 8 hours of dementia training within 30 days of hire. HR assigned appropriate training to Staff person A and they were removed from the schedule until completion.

- By 6/2/2024, the ALA, Nurse Manager and HR will have ensured adequate dementia care trainings are provided to direct care staff moving forward.

- Beginning 6/2/2024, the ALA or designee with audit 3 newly hired agency employees training records weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x1 to validate sustained compliant (Exhibit F1- Audit Tool).

- Results of the audit will be discussed during quarterly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.

Licensee's Proposed Overall Completion Date: *06/30/2024*

Not Implemented ([redacted] - 07/31/2024)