

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

August 13, 2024

[REDACTED], EXECUTIVE DIRECTOR
1263 S CEDAR CREST BLVD SENIOR LIVING I OPCO LLC
[REDACTED]
[REDACTED]

RE: RITTENHOUSE VILLAGE AT LEHIGH
VALLEY
1263 S CEDAR CREST BOULEVARD
ALLENTOWN, PA, 18103
LICENSE/COC#: 22301

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/02/2024 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: RITTENHOUSE VILLAGE AT LEHIGH VALLEY License #: 22301 License Expiration: 08/23/2024
 Address: 1263 S CEDAR CREST BOULEVARD, ALLENTOWN, PA 18103
 County: LEHIGH Region: NORTHEAST

Administrator

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

Legal Entity

Name: 1263 S CEDAR CREST BLVD SENIOR LIVING I OPCO LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 Date: 03/07/2016 Issued By: Salisbury Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 107 Waking Staff: 80

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 07/02/2024

Inspection Dates and Department Representative

07/02/2024 - On-Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 110 Residents Served: 76

Secured Dementia Care Unit
 In Home: Yes Area: Shine-1st floor Capacity: 34 Residents Served: 19

Hospice
 Current Residents: 2

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 76
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 31 Have Physical Disability: 1

Inspections / Reviews

07/02/2024 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 07/27/2024

07/29/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 08/12/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/02/2024

Inspections / Reviews (*continued*)

08/07/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 08/12/2024

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: 08/12/2024

08/13/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: 08/12/2024

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

86b - Bathroom

1. 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 bathroom of room #306 does not contain a window that opens to the outside. This bathroom's exhaust fan was inoperable at the time of inspection.

Plan of Correction

Accept () - 08/07/2024)

1. Exhaust fan was repaired by the Maintenance Director on 7/3/2024
2. Maintenance Director to audit 10% of community apartments bi-weekly for two months starting on 7/24/24
3. Maintenance Director in-serviced on 86.b by Executive Director on 7/3/24
4. Executive Director to monitor to ensure plan is followed.

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

Implemented () - 08/13/2024)

103f - Refrigerator/Freezer Temps

2. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

The ice cream chest freezer in the home's main kitchen did not have a thermometer.

Plan of Correction

Accept () - 08/07/2024)

1. A thermometer was installed at the time of the inspection to make an immediate correction.
2. Culinary Director and culinary staff to be educated on 103.f by the Executive Director by 8/1/24
3. Culinary Director to audit all refrigerators/freezers bi-weekly for two months
4. Executive Director to monitor to ensure plan is followed.

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

Implemented () - 08/13/2024)

103g - Storing Food

3. Requirements

2600.

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

Description of Violation

Toasted Oats Cereal was found in the Kitchen on a shelf, in an opened bag with no label or date.

Plan of Correction

Accept () - 08/07/2024)

1. The cereal package was labeled and dated at time of inspection to make an immediate correction.
2. Culinary Director and culinary staff to be educated on 103.g by the Executive Director by 8/1/24
3. Culinary Director to audit all the kitchen food storage bi-weekly for two months

103g - Storing Food (continued)

4. Executive Director to monitor to ensure plan is followed.

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

Implemented () - 08/13/2024)

125a - Combustible Storage

4. Requirements

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A broom covered in dryer lint was noted on the floor between the clothes dryer and the wall posing a risk of fire.

Plan of Correction

Accept () - 08/07/2024)

1. The broom was cleaned at the time of the inspection to make an immediate correction.
2. Care staff who use the dryer to be in-serviced on 125.a by 8/1/24 by Executive Director/designee
3. Maintenance Director to audit dryer lint bi-weekly for two months starting on 7/24/24
4. Executive Director to monitor to ensure plan is followed.

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

Implemented () - 08/13/2024)

141b1 - Annual Medical Evaluation

5. Requirements

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's current medical evaluation was completed on () and the next most recent medical evaluation was completed on ()

Plan of Correction

Accept () - 07/29/2024)

1. An updated annual medical evaluation for resident #1 was completed on 6/11/24
2. Director of Health and Wellness inserviced on 141.b by Regional Director of Clinical Services on 7/26/24
3. Director of Health and Wellness to audit 10% of resident charts bi-weekly for two months to ensure compliance with 141.b

Licensee's Proposed Overall Completion Date: 07/26/2024

Implemented () - 08/13/2024)

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.

181c - Self-administration Assessment (continued)

Description of Violation

Resident # 3's RASP and DME, dated [REDACTED] indicate the resident cannot self-administer medications. The following medications were noted in Resident #3's room:

- Brimonidine 0.2% eye drops; 1 drop in each eye twice daily.
- Refresh Opti Drops 0.5-0.9%, one drop in affected eye 4x daily.
- Restasis EMU 0.5% eye drops, one drop in each eye every 12 hours.

Repeat Violation-11/7/23.

Plan of Correction

Accept ([REDACTED] - 08/07/2024)

1. Resident #3 DME and RASP were updated on 07/19/2024 that the Resident can self-administer some medications but not others-.
2. Med List was reviewed by Nurse Practitioner with Resident regarding medications [REDACTED] can self-administer, some of which have been discontinued since evaluation.
3. Education was provided to the Nursing supervisor Staff was on 7/24/2024 by DHW. The education presented was on Self-administration orders, the DME administration section, as well as updating the RASP when medication administration changes occur.
4. Director of Health and Wellness to audit 10% of resident charts for compliance with 181.c. Audit to be completed bi-weekly for two months starting 8/1/24
5. Executive Director to monitor to ensure plan is followed.

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

Implemented ([REDACTED] - 08/13/2024)

187d - Follow Prescriber's Orders

7. Requirements

2600.

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

Description of Violation

Resident #3' Medication Administration Records indicate they are prescribed the following medications that were not on hand:

- Fluticasone Spray 50 mcg, 2 sprays in each nostril daily.
- Nystatin Powder 100, 000 units apply daily
- Triamcinolon ointment 0.5% apply 3x daily
- Estradiol Cream 0.1% M-W-F at bedtime

Resident #13 is also prescribed Epinephrine Injection 0.3mg. The order reads "may keep one pen on hand when traveling". Resident #3 confirmed they keep one pen with them; however, a second pen is not in the medication cart for staff to access in the event of an emergency.

Plan of Correction

Accept ([REDACTED] - 08/07/2024)

1. Resident #3 DME and RASP were updated on 07/19/2024 that the Resident can self-administer some medications but not others-.
2. Med List was reviewed by Nurse Practitioner with Resident regarding medications [REDACTED] can self-administer, some of which have been discontinued since evaluation.

187d - Follow Prescriber's Orders (continued)

- 3. Education was provided to the Nursing supervisor Staff was on 7/24/2024 by DHW. The education presented was on Self-administration orders, the DME administration section, as well as updating the RASP when medication administration changes occur.
- 4. Director of Health and Wellness to audit 10% of resident charts for compliance with 187.d. Audit to be completed bi-weekly for two months starting 8/1/24
- 4. Executive Director to monitor to ensure plan is followed

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

Implemented () - 08/13/2024)

224a - Preadmission Screen Form

8. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2, who was admitted on [REDACTED], has a Preadmission Screening that does not include a date when it was completed.

Plan of Correction

Accept () - 07/29/2024)

- 1. Director of Health and Wellness in-serviced on 224.a by Executive Director on 7/26/24
- 2. Director of Health and Wellness to audit 10% of resident charts for compliance with 187.d. Audit to be completed bi-weekly for two months starting 8/1/24
- 3. Executive Director will review and sign off on all preadmission screening forms prior to ensure compliance with 224.a

Licensee's Proposed Overall Completion Date: 07/26/2024

Implemented () - 08/13/2024)

225c - Additional Assessment

9. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident #1's current Assessment and Support Plan was completed on [REDACTED] and the next most recent Assessment and Support Plan is dated [REDACTED]

Plan of Correction

Accept () - 08/07/2024)

- 1. Director of Health and Wellness in-serviced on 225.c by Executive Director on 7/26/24
- 2. Director of Health and Wellness to audit 10% of resident charts for compliance with 225.c. Audit to be completed bi-weekly for two months starting 8/1/24
- 3. The completed Assessment and RASP date has been corrected in the computer tracking system used to track the

225c - Additional Assessment (continued)

completion of resident Assessments and RASPS.

4. Executive Director to monitor to ensure plan is followed.

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

Implemented ([REDACTED] - 08/13/2024)