

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

November 15, 2024

[REDACTED]
FRIENDS BOARDING HOME OF WESTERN QUARTERLY MEETING
[REDACTED]

RE: FRIENDS BOARDING HOME OF
WESTERN QUARTERLY MEETING
147 WEST STATE STREET
KENNETT SQUARE, PA, 19348
LICENSE/COC#: 14002

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/12/2024 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: FRIENDS BOARDING HOME OF WESTERN QUARTERLY MEETING License #: 14002 License Expiration: 02/23/2025

Address: 147 WEST STATE STREET, KENNETT SQUARE, PA 19348

County: CHESTER Region: SOUTHEAST

Administrator

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

Legal Entity

Name: FRIENDS BOARDING HOME OF WESTERN QUARTERLY MEETING

Address: [REDACTED]

Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 03/28/1988 Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 37 Waking Staff: 28

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:

Reason: Incident Exit Conference Date: 09/12/2024

Inspection Dates and Department Representative

09/12/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 68 Residents Served: 37

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: 37

Diagnosed with Mental Illness: 3 Diagnosed with Intellectual Disability: 0

Have Mobility Need: 0 Have Physical Disability: 0

Inspections / Reviews

09/12/2024 Partial

Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 10/18/2024

10/28/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 11/15/2024

Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/05/2024

Inspections / Reviews (*continued*)

11/15/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2024

Reviewer: [REDACTED]

Follow Up Type: *Bypass Document
Submission*

11/15/2024 Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2024

Reviewer: [REDACTED]

Follow Up Type: *Not Required*

141b1 - Annual Medical Evaluation

1. Requirements

2600.

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

Description of Violation

Resident [redacted] annual medical evaluation, dated [redacted], did not include the special health or dietary needs of the resident or the body positioning and movement stimulation for residents, if appropriate.

Plan of Correction

Accept [redacted] - 11/15/2024)

Nurses meeting held to discuss the process for obtaining the DME's timely and ensuring all sections are completed. The process also identifies the need to obtain a new DME with any change in condition including the application of a wander guard

All health center nurses were present, and information provided by [redacted] and [redacted] PC administrators

Regular chart audits will be performed by the administrator post admission, annually and when any change in condition identified

I have attached the record of training with the date of the meeting indicated. 10/17/24

We use a documentation check list to track DME's and this is maintained by the Director of Personal Care. This will be the indicator of when a DME is due and or obtained so the documentation can be audited for content.

Licensee's Proposed Overall Completion Date: 10/28/2024

Implemented [redacted] - 11/15/2024)

227d - Support Plan Medical/Dental

2. Requirements

2600.

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

Description of Violation

The assessment for resident [redacted], dated [redacted], does not indicate that the resident has a need for a wander guard. The resident's support plan does not document how this need will be met.

Plan of Correction

Accept [redacted] - 11/15/2024)

Another topic at the nurses meeting was the completion of the RASP and need to update this document with any change in condition including application of a wander guard. Emphasis placed on importance of ensuring the RASP and DME are compatible, and all sections completed.

All health center nurses were present, and information provided by [redacted] and [redacted] PC administrators

Regular chart audits will be performed by the administrator post admission, annually and when any change in condition identified

I have attached the record of training with the date of the meeting indicated. 10/17/24

We use a documentation check list to track DME's and RASPS and this is maintained by the Director of Personal

227d Support Plan Medical/Dental (continued)

Care. This will be the indicator of when a DME is due and or obtained so the documentation can be audited for content.

Licensee's Proposed Overall Completion Date: 11/05/2024

Implemented [REDACTED] 11/15/2024)

252 - Record Content**3. 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.
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 [REDACTED] record does not include the color of hair, the color of eyes, or the record of incident reports for the individual resident.

Repeat Violation: 10/02/2023, et al

252 Record Content (continued)

Plan of Correction

Accept ([REDACTED] - 11/15/2024)

Each nurse was provided with the list of required chart contents. We also discussed need to ensure all sections of the admission paperwork is completed and not to leave any section blank

All health center nurses were present, and information provided by [REDACTED] and [REDACTED] PC administrators

Regular chart audits will be performed by the administrator post admission, annually and when any change in condition identified

I have attached the record of training with the date of the meeting indicated. 10/17/24

The Director is aware of all new admissions and will audit each chart within a week of the admission date to ensure all documentation is present

Licensee's Proposed Overall Completion Date: 11/05/2024

Implemented [REDACTED] - 11/15/2024