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

December 4, 2024

[redacted]
IVQ LANSDALE OPCO LP
[redacted]

RE: TRADITIONS OF LANSDALE
1800 WALNUT STREET
LANSDALE, PA, 19446
LICENSE/COC#: 14521

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/20/2024 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: *TRADITIONS OF LANSDALE* **License #**: *14521* **License Expiration**: *02/28/2025*

Address: *1800 WALNUT STREET, LANSDALE, PA 19446*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *IVQ LANSDALE OPCO LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *Other* **Date**: *02/28/1986* **Issued By**: *Hatfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *109* **Waking Staff**: *82*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/20/2024*

Inspection Dates and Department Representative

09/20/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *150* **Residents Served**: *79*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Daybreak* **Capacity**: *21* **Residents Served**: *20*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *79*

Diagnosed with Mental Illness: *3*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *30*

Have Physical Disability: *0*

Inspections / Reviews

09/20/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/13/2024*

10/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/25/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/22/2024*

Inspections / Reviews *(continued)*

10/23/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/25/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/20/2024*

11/21/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/25/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/25/2024*

12/04/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/25/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

42b - Abuse

1. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident [redacted], a resident of the secured dementia care unit, eloped from the home on [redacted]. The resident was last seen by staff members at approximately 3:40pm in the memory care unit courtyard. Resident [redacted] was not accompanied by a staff member while in the courtyard. Resident [redacted] absence went unnoticed by the home's staff for some time until approximately 5pm. Staff members of the memory care unit identified that Resident [redacted] was missing when they attempted to locate them for dinner. After a search that spanned hours, Resident [redacted] was brought back to the home by the local fire department/police at 1:25am on 9/2/24. The resident was able to indicate which door they had left from earlier and the home discovered that the locking mechanism on the courtyard door was faulty, allowing the door to be opened without entering a code to unlock the door.

Resident [redacted] was verbally abused by Staff Member A on [redacted] at approximately 4:50am. An outside contractor performing renovations in the home overheard Staff Member A stating "Sit in your [redacted] chair, sit the[redacted] down and stay the [redacted] down" to Resident [redacted]. The current support plan for Resident [redacted] indicates that the resident is able to ambulate and transfer independently and likes to wander in the unit at night. Resident [redacted] also has a documented moderate need for understanding directions and short term memory, which requires for staff to provide simple, short directions and cues to the resident. Staff Member A was subsequently terminated.

Plan of Correction ***Accept [redacted] - 10/23/2024)***

Resident [redacted] - Immediate Corrective Actions: When noted that Resident [redacted] was not in the courtyard, or in the memory care neighborhood when it was time for dinner, staff notified the Manager on Duty and moved quickly to follow all of the steps in the Elopement policy.

Resident [redacted] - Additional Corrective Actions: Through the process of trying to locate Resident[redacted] within the community, it was noted that the secured door at the end of the courtyard, did not latch, and could be pushed open. A call was placed to Fushion Factors on [redacted] to inspect and repair the secured door. Fushion Factors came out [redacted] and identified three areas of concern, and repaired the door. Until the door was fixed, it was secured, as it is not an exit. A sign was posted by the Executive Director that our Residents were unable to use that courtyard unless they were accompanied by staff. The incident was reviewed at the All Staff Meeting, facilitated by the Executive Director on [redacted], along with a review of the Elopement Policy. We also included an additional inservice facilitated by Fox Therapy Services related to Managing Behaviors when working with Residents with Dementia.

Resident [redacted] - Ongoing Quality Assurance Actions: As part of our Emergency Preparedness Quarterly QA, the Executive Director and the department Head team will conduct an Elopement Drill, once per quarter. The RASP for Resident [redacted] was updated by the Memory care Director on [redacted] following the incident. Going forward, all Reidents in our Memory Care neighborhood will be accompanied by staff when spending time in the secured courtyards. The Courtyard Doors will be checked by Maintenance/Housekeeping staff daily during rounds.

Resident [redacted] - Immediate Corrective Actions: When the report was made in regard to the statements that were overheard, the Executive Director and the Resident Care Director took immediate action and started an investigation to identify the Resident involved. Based on the reaction of Staff Member A when we reached out to follow-up,

42b Abuse (continued)

employment was terminated immediately. The investigation was completed within a few hours, and the incident was reported. An Act 13 was filed and a Reportable Incident form was sent to DHS. We followed our Abuse, Neglect, and Exploitation Reporting Policy.

Resident #[redacted] Additional Corrective Actions: Staff Member A is no longer employeed by the home, Effective 8/16/24.

Resident [redacted] Ongoing Quality Assurance Actions: An inservice was set up for the All Staff meeting held on 8/28/24. Fox Therapy Services facilitated the 1st inservice in a series of 3 trainings, related to working with Residents that have dementia. This inservice was "Communication with Residents with Dementia."
The Executive Director will be responsible to facilitate an inservice to review the Abuse, Neglect, and Exploitation Reporting Policy at the next All Staff Meeting to be held on [redacted] A review of Resident Rights will be included as part of the inservice. Continuing Education through Relias will be monitored on a monthly basis, by the Business Office Manager.

Updated 10/22/24
To monitor ongoing compliance with our residents, the Resident Life Director, the Resident Care Director, or the Executive Director will review the Resident Rights and Complaint Procedure each month at the Resident Council Meeting, which is held on the 4th Tuesday at 2pm. To monitor ongoing compliance with our staff the Resident Care Director or the Executive Director will review the Resident Rights and Complaint Procedure each month at the all staff meeting held the last Wednesday at 2:30pm.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented ([redacted] - 12/04/2024)

51 - Criminal Background Check

2. Requirements

2600.
51. Criminal History Checks - 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).

Description of Violation

Staff Member A whose hire date was [redacted], did not have a criminal background check completed until [redacted]

Repeat Violation Date: 2/14/24 et al.

Plan of Correction ***Accept [redacted] - 10/23/2024)***

Immediate Action: Staff Member A is no longer employed at the community as of [redacted]. The Business Office Manager had conducted an audit of Employee files April 17, 2024 and was unable to locate a criminal background check for Staff Member A. The background check was on run on 4/17/24, and was clear.

Additional Corrective Action: The Business Office Manager (BOM) completed a full audit of all current employee files, to ensure that everyone has a criminal background check on file.

Ongoing Quality Assurance Actions: The BOM has updated the Employee File Checklist and the date the Background Check is Requested and the Date it is Received is inserted on the checklist. The checklist will be reviewed to ensure

51 Criminal Background Check (continued)

the criminal background check has been received before the new employee can start working in the community. Per the "Payroll and Personnel Requirements and Staff Person Training" policy, the BOM will be responsible to review the employee files each quarter, and the Executive Director will review the audit, to be presented at the Quarterly QA Meeting to maintain compliance and prevent a reoccurence of this violation.

Updated on 10/22/24

The Business Office Manager completed an audit of all current employee files on 10/06/24 to ensure that everyone has a criminal background check on file.

Licensee's Proposed Overall Completion Date: *10/22/2024*

Implemented [redacted] - 12/04/2024)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive orientation on the following topics until [redacted]:

1. Evacuation procedures.

2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.

3. The designated meeting place outside the building or within the fire safe area in the event of an actual fire.

4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.

5. The location and use of fire extinguishers.

6. Smoke detectors and fire alarms.

7. Telephone use and notification of emergency services.

Repeat Violation Date: 2/14/24 et al.

Plan of Correction ***Accept [redacted] - 10/17/2024)***

Immediate Corrective Actions: Staff Member B is an agency staff member, and has not been back to the

65a - FS Orientation 1st Day (continued)

community since 9/02/24. This staff person was provided with the training outlined for 1st Day orientation on 8/11/24, as new managers in the community were unaware of previous days worked back in January and February 2024. Training will be updated if Staff person B returns.

Additional Corrective Actions: Any agency personnel working in the community will complete 1st Day Orientation and 40 Hour Training when they come into the community for the first time. Any staff members coming in from agency that have been to the community previously will complete the training in it's entirety to ensure compliance. Training is being completed by the Executive Director, or the Maintenance Director.

Ongoing Quality Assurance Actions: The Executive Director created an updated "Agency Staff PA. Training Record," sheet that will be kept in a binder, after the training is completed. The Resident Care Coordinator will review prior to the Quarterly QA Meeting and report on compliance.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented [redacted] - 12/04/2024)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person B completed [redacted] 40th scheduled work hour on [redacted] 4. However, this staff person did not complete training in the following topics:

1. Resident rights.

2. Emergency medical plan.

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).

4. Reporting of reportable incidents and conditions.

Repeat Violation Date: 2/14/24 et al.

Plan of Correction ***Accept ([redacted] - 10/17/2024)***

Immediate Corrective Actions: Staff Member B is an agency staff member, and has not been back to the community since [redacted]. This staff person was provided with the training outlined for 1st Day orientation on [redacted], as new managers in the community were unaware of previous days worked back in January and February 2024. Training will be updated if Staff person B returns.

Additional Corrective Actions: Any agency personnel working in the community will complete 1st Day Orientation and 40 Hour Training when they come into the community for the first time. Any staff members coming in from agency that have been to the community previously will complete the training in it's entirety to ensure compliance.

65b - Rights/Abuse 40 Hours (continued)

Training is being completed by the Executive Director, or the Maintenance Director.

Ongoing Quality Assurance Actions: The Executive Director created an updated "Agency Staff PA. Training Record," sheet that will be kept in a binder, after the training is completed. The Resident Care Coordinator will review prior to the Quarterly QA Meeting and report on compliance.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented [redacted] - 12/04/2024)

227g -Support Plan Signatures

5. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

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

Repeat Violation Date: 2/14/24 et al

Plan of Correction ***Accept [redacted] - 10/23/2024)***

Immediate Corrective Actions: The Memory Care Director met with Resident [redacted] and obtained an updated signature with the date of 9/20/24.

Additional Corrective Actions: The Memory Care Director completed an audit of all Rasps and signatures and dates are in place.

Ongoing Quality Assurance Actions: The Resident Care Director and Resident Care Coordinator will audit a sample of Resident Records every month per the Quarterly QA Process, beginning in November 2024.

Updated 10/22/24

The Memory Care Director started the audit of all RASPs on 9/20/24 following the inspection, and completed the audit in it's entirety on 10/01/24, ensuring that all current Residents have a RASP in place that have signatures and dates.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented [redacted] - 12/04/2024)

233d - Electronic/Magnetic System

6. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

233d - Electronic/Magnetic System *(continued)*

Description of Violation

The door in the memory care unit courtyard malfunctioned and did not lock properly on [redacted], which allowed for the elopement of Resident [redacted] on [redacted].

Plan of Correction ***Accept [redacted] - 10/17/2024)***

Immediate Corrective Actions: Through the process of trying to locate Resident [redacted] within the community, it was noted that the secured door at the end of the courtyard, did not latch, and could be pushed open. A call was placed to Fushion Factors on 9/02/24, to inspect and repair the secured door.

Additional Corrective Actions: Fushion Factors came out 9/03/24,and identified three areas of concern, and repaired the door.

Ongoing Quality Assurance Actions: The Courtyard Doors will be checked by Maintenance/Housekeeping staff daily during rounds.

Licensee's Proposed Overall Completion Date: *11/01/2024*

Implemented ([redacted] - 11/21/2024)