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

October 21, 2024

[redacted]
EAGLEVIEW LANDING LP
[redacted]
STE 400
[redacted]

RE: EAGLEVIEW LANDING
650 STOCKTON DRIVE
EXTON, PA, 19341
LICENSE/COC#: 14698

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/30/2024 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: *EAGLEVIEW LANDING* **Licen e #**: *14698* **Licen e Expiration**: *09/13/2025*

Address: *650 STOCKTON DRIVE, EXTON, PA 19341*

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

Administrator

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

Legal Entity

Name: *EAGLEVIEW LANDING LP*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I 2* **Date**: *03/27/2019* **I ued By**: *Uwchlan Twp*

Staffing Hours

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

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *09/30/2024*

Inspection Dates and Department Representative

09/30/2024 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *121* **Residents Served**: *77*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Garden House* **Capacity**: *46* **Residents Served**: *24*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *77*

Diagnosed with Mental Illness: *46*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *32*

Have Physical Disability: *44*

Inspections / Reviews

09/30/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/12/2024*

10/18/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *10/18/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/28/2024*

Inspections / Reviews *(continued)*

10/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2024*

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

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted], agency staff A yelled and cursed at SDCU resident [redacted] and then threw blankets on top of the resident while [redacted] was laying on the bed.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

Immediate action: Agency Staff A was immediately sent home from community and placed on a "Do Not Return" status. Resident [redacted] was assessed by nurse and found to have no injury. Incident was reported to PCP, POA, DHS and Protective Services. Both Protective Services and DHS sent representatives to speak with resident and staff. Resident had no recollection of the incident. All agency staff are trained upon their first visit to the community regarding Residents Rights and the OAPSA. BOD audits training documentation for all agency staff each week. All internal staff will be trained on Residents Rights by [redacted] by General Manager or designee. This training will continue to be reviewed at each monthly All Staff Meeting for the next 6 months by General Manager or designee.

Licensee's Proposed Overall Completion Date: *10/18/2024*

Implemented [redacted] 10/21/2024)

187d - Follow Prescriber's Orders

2. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed an Xray of the [redacted] and [redacted] on [redacted]. However, as of [redacted], the Xray has not been completed.

Plan of Correction ***Accept [redacted] - 10/18/2024)***

At the time of this occurrence, the resident was in isolation due to suitemate having COVID. Staff unable to locate hold order for x-ray. PCP office unable to locate hold order and new order was received for xray. Xray completed on [redacted] and findings were "No fracture or significant bony deformity; diffuse soft tissue prominence."
All staff nurses were trained by HSD, effective [redacted], in newly adopted system that includes two separate binders, one for medication orders and one for diagnostic testing. All orders from prescribers are to be delivered exclusively via eFax to the Health Services Director, Garden House Director and Wellness Nurse. These nurses will be responsible for printing out eFax orders and verifying implementation of orders on the date they are received.
Health Services Director or designee will be responsible for auditing the daily orders each week to ensure that all orders have been fully implemented and corresponding documentation is included in the electronic health record for each resident beginning [redacted] for 3 months unti [redacted].

Licensee's Proposed Overall Completion Date: *10/11/2024*

Implemented [redacted] 10/21/2024)

227d - Support Plan Medical/Dental

3. Requirements

227d - Support Plan Medical/Dental *(continued)*

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

On [redacted] resident[redacted] verbally expressed [redacted] "should just jump out of the window." The [redacted] were not noted in the residents most recent RASP dated [redacted]

Plan of Correction ***Accept [redacted] - 10/18/2024)***

mmediate action: Staff member documented the statement in the progress notes. POA was on the phone with Resident [redacted] when this statement was expressed.

RASP addendum was updated to reflect this statement. Resident has been under the care of a Behavioral Health Nurse practitioner since [redacted] who is aware of the resident's statement.

All staff will be educated on steps that must be taken when a resident expresses suicidal ideations, such as, but not imited to ensuring resident does not have a plan or means to or access to items that could cause bodily injury, reporting statements immediately to Wellness Nurse/GHD/HSD/Designee and updating the RASP to reflect the dentified concern and a plan to meet the need.

raining to completed by General Manager/Designee by [redacted].

Progress notes to be reviewed daily by Wellness Nurse/GHD/HSD to identify any concerns of residents at risk for self harm. To start [redacted] for 3 months until [redacted]

Licensee's Proposed Overall Completion Date: *10/18/2024*

Implemented [redacted] 10/21/2024)