

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

November 4, 2024

[REDACTED]
HUMANGOOD PENNSYLVANIA
[REDACTED]

RE: RYDAL PARK PERSONAL CARE
1515 THE FAIRWAY
RYDAL, PA, 19046
LICENSE/COC#: 13812

[REDACTED],
As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/09/2024 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: RYDAL PARK PERSONAL CARE License #: 13812 License Expiration: 02/19/2025
Address: 1515 THE FAIRWAY, RYDAL, PA 19046
County: MONTGOMERY Region: SOUTHEAST

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: HUMANGOOD PENNSYLVANIA
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 75 Waking Staff: 56

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Complaint, Incident Exit Conference Date: 10/09/2024

Inspection Dates and Department Representative

10/09/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
License Capacity: 72 Resident Served: 51
Secured Dementia Care Unit
In Home: Yes Area: Memory Care Capacity: 22 Resident Served: 18
Hospice
Current Resident: 0
Number of Residents Who:
Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 51
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 24 Have Physical Disability: 0

Inspections / Reviews

10/09/2024 Partial
Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 11/03/2024

Inspections / Reviews (*continued*)

11/04/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/04/2024

Reviewer: [REDACTED]

Follow-Up Type: *Bypass Document
Submission*

11/04/2024 - Bypass Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/04/2024

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], at approximately 3:20pm, Resident [redacted] was disrupting other residents in the memory care unit. Resident [redacted] has a Private Pay Aide (listed as Staff Member A for this report) Staff Member A took Resident [redacted] out of the memory care unit to redirect them due to their behaviors. Staff Member A brought the resident to the first floor to sit on a bench outside the facility. The homes external video surveillance captured the following interaction between Resident [redacted] and Staff Member A. Per the video, Staff Member A appeared to be talking to the resident, telling them to sit down. Resident [redacted] was repeatedly refusing to sit on the bench and was attempting to walk back into the building through the entrance. Staff Member A stood in front of the entrance door and blocked Resident [redacted] from entering the building. This encounter of Resident [redacted] refusing to sit and wanting to enter the building and Staff Member A blocking the entrance happened numerous times.

While the Staff Member A continued to block Resident [redacted], Staff Member B observed the interaction and reported to staff member C what was taking place in front of the building. Staff Member B reported that they overheard Resident [redacted] telling the Aide that they were cold and wanted to go back inside. Staff Member C is observed on the video at 4:08 pm talking to Staff Member A. Per Staff Member C, they witnessed Staff Member A telling Resident [redacted] to sit down and repeatedly say, "You need to sit. Now, do as I say and sit." Resident [redacted] again claimed they were cold and continued to try to enter the facility. Staff Member C informed Staff Member A that they could not prevent the resident from reentering the facility. Per Staff Member C's statement, the resident was wearing slippers and had a look of distress about them. At 4:08 pm, Resident [redacted], Staff Member A, and Staff Member C entered the facility and Resident [redacted] returned to the memory care unit.

Plan of Correction

Accept [redacted] - 11/04/2024)

Preparation and execution of this Response and Plan of Correction does not constitute an admission or agreement by HumanGood/Rydal Park Personal Care Facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies and Plan of Correction. The Plan of Correction is being prepared and/or executed solely because it is required by State and Federal Law. For the purposes of any allegation that the facility is not in substantial compliance with state requirements of participation, the Response and Plan of Correction constitutes the facility's allegation of compliance in accordance with section 2600.3 (c) of the Regulatory Compliance Guide.

Staff Member did not return to duty as a private care giver after incident.

Private Duty and volunteers are going to be taught the Orientation Training by Administrator or Nursing on duty before starting with a resident in the home. Current private duty/ volunteers will be completing the education on or before Nov 8, 2024. Please see the attachment for the contents of the education.

A communication was sent on 11/1/2024 to the residents in the home and their families regarding the policy related to hired private duty companions or volunteers. Please see the attached letter.

An audit of the education will be completed by the Administrator or the nursing supervisor for private care givers will be completed quarterly for the next 12 months. Findings will be reported to QA.

Licensee's Proposed Overall Completion Date: 11/08/2024

Implemented [redacted] - 11/04/2024)

42s - Privacy

2. Requirements

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted] at 10am, the home has cameras that are aimed to the exit doors on each floor and can capture residents' apartments. The cameras are located at the end of the hallways on each floor.

Plan of Correction

Accept [redacted] - 11/04/2024)

The cameras in the home are designed to view entrances and exist for the home. The camera views have been repositioned to eliminate any other areas not intended to be in view. Please see the attached photos with updated views for each camera.

Buildings and ground manger or maintenance manager will provide still images of the camera angles quarterly to the Administrator for reporting at QA to ensure camera views are within regulatory compliance. This audit will be completed for 12 months starting in December of 2024.

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

Implemented [redacted] - 11/04/2024)

65d - Initial Direct Care Training

3. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person D, hired on [redacted], Does not have documentation of the completion and passing of the Department approved direct care training course and the competency test.

Plan of Correction

Accept [redacted] - 11/04/2024)

Staff Person D was removed from care on the date of the survey. Staff person D then completed the Bureo of Human Servies Licensing on 10/10/2024. Once this education was completed [redacted] returned to duty.

An audit of the team members working in the home was completed on 10/31/2024 to determine if an active CNA icense or DHS training completed. The results of the audit showed that current team members had either their CNA or DHS education in compliance as of 10/31/2024.

Please see attached documentation of the DHS training for staff person D as well as the audit that was completed on 10/31/2024.

Education was completed with the Human Resources team to complete monthly random audits of team member files to ensure compliance with this regulation. This audit will be completed for 12 months and reported to QA monthly. Please see attached education form for the Human resources team members.

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

Implemented [redacted] 11/04/2024)

202 - Prohibitions

4. Requirements

2600.

202. The following procedures are prohibited:

Description of Violation

On [REDACTED] at 2:30pm, Resident [REDACTED] was taken outside by Staff Member A (a Private Pay Aide). Resident [REDACTED] did not want to sit down and attempted to re-enter the building. Staff Member A proceeded to block Resident [REDACTED] from entering the building multiple times. Resident [REDACTED] wished to go inside because they were cold but they were prevented from doing so.

Plan of Correction

Accept [REDACTED] 11/04/2024)

Staff Member did not return to duty as a private care giver after incident.

Staff Members of the home are being educated on dressing residents of the home in appropriate seasonal clothing or as their suite temperature dictates. This education will be completed by November 8, 2024.

Education will be completed quarterly at change of season to ensure proper dressing is completed by the staff members. Residents will be reminded about seasonal clothing changes during resident council meeting quarterly by Resident Council President or Administrator. This will continue for 12 months and be reported in the Resident council minutes and to QA.

Licensee's Proposed Overall Completion Date: 11/08/2024

Implemented [REDACTED] - 11/04/2024)