

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

February 13, 2025

[REDACTED], REGIONAL VP OF OPERATIONS
MCAP WILLOW GROVE OPERATOR LLC
[REDACTED]
[REDACTED]

RE: COMMONWEALTH SENIOR LIVING
AT WILLOW GROVE
1120 YORK ROAD
WILLOW GROVE, PA, 19090
LICENSE/COC#: 13994

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/13/2024, 11/14/2024 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: COMMONWEALTH SENIOR LIVING AT WILLOW GROVE License #: 13994 License Expiration: 10/08/2025
Address: 1120 YORK ROAD, WILLOW GROVE, PA 19090
County: MONTGOMERY Region: SOUTHEAST

Administrator

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

Legal Entity

Name: MCAP WILLOW GROVE OPERATOR LLC
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: C-2 LP Date: 02/15/1990 Issued By: Commonwealth of PA&LI

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 115 Waking Staff: 86

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal Exit Conference Date: 11/14/2024

Inspection Dates and Department Representative

11/13/2024 - On-Site: [Redacted]
11/14/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity:	122	Residents Served:	69
Secured Dementia Care Unit			
In Home:	Yes	Area:	Sweet Memories
Capacity:	30	Residents Served:	20
Hospice			
Current Residents:	4		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	69
Diagnosed with Mental Illness:	1	Diagnosed with Intellectual Disability:	1
Have Mobility Need:	46	Have Physical Disability:	3

Inspections / Reviews

11/13/2024 - Full
Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 12/15/2024

Inspections / Reviews (*continued*)

12/16/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/07/2025

Executive Director

Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 12/21/2024

12/24/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: 02/07/2025

Executive Director

Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 01/22/2025

02/13/2025 - Document Submission

Submitted By: [REDACTED] Date Submitted: 02/07/2025

Executive Director

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

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/22/24, a Hospice Aid reported to staff member A that resident #1 has concerns about resident#1 neglect. Resident #1 did not receive morning care of bathing, dressing, grooming, and incontinence care. Resident #1 was found in a hospital gown from previous evening and an incontinence brief that was saturated with urine at 11:20 A.M. The home did not submit an incident report regarding the alleged neglect of resident to the Department.

Plan of Correction

Accept (█ - 12/24/2024)

Resident Care Director or designee will submit any report or incident of potential abuse or neglect of a resident within 24 of initial report per regulation. RCD or designee will review 24 reports daily moving forward to identify any reportable events. As of 12/12/24 all reportable events will be reported to the Executive Director or designee same day of occurrence. All reports will be reviewed by RCD, ED or designee to ensure compliance and submission timely. Resident Care Director or assigned designee will in-service all staff on abuse and neglect and mandated reporting regulations. In-servicing of wellness staff began on 12/12/24 and will be completed by 12/31/24

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented (█ - 02/11/2025)

25b SOPc - Rent Rebate: Signed Statement

2. Requirements

2600.

25b.c. A statement signed by the resident, and the resident's designated person if applicable, at the time of admission, informing the resident that the information required in subsection (a) is to be kept in the resident's record.

Description of Violation

The resident-home contract dated █, for Resident #2 does not include a statement signed by the resident and the resident's designated person (if applicable), at the time of admission, that the resident has been informed that information related to rent rebate collection by the home will be kept in the resident's record.

Plan of Correction

Accept (█ - 12/24/2024)

Signature from Resident #2 obtained and corrected at time of inspection. Executive Director completed audit of signed resident contracts to ensure all applicable signatures are in place as of 12/10/24. ED or BOM will double check all new signed contracts prior to them being placed in resident files to ensure all signatures are in place. ED or BOM are responsible for all contract signings in the community either in person or electronically. ED and BOM implemented system 12/10/24

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented (█ - 02/11/2025)

26a - Quality Management Plan

3. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

26a - Quality Management Plan (continued)

Description of Violation

The home has not implemented its quality management plan as it has not conducted a quality management. According to the home's policy a quality management review is conducted yearly.

Plan of Correction

Directed () - 12/24/2024)

ED scheduled Quality management as of 12/10/24, first meeting scheduled for 12/17/2024 and meeting will be held every 3 months on the 3rd Tuesday of the month moving forward. Attendees will include ED, RCD, ARCD, Maintenance director, Dining service director, Program director, and Business office manager or designees. Account of meeting will be completed and kept on file.

DIRECTED PLAN OF CORRECTION: In addition to the above plan of correction, within 15 business days, the administrator or designee shall update the homes written policy for Quality Management to include changes to the frequency of scheduled meetings. The updated policy and the meeting minutes shall be kept and made available for Department review upon request.

Directed Completion Date: 12/21/2024

Implemented () - 02/11/2025)

42c - Treatment of Residents

4. Requirements

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

Description of Violation

On 11/13/24 at approximately 10:45am, there was a strong odor present in the hallway near resident #3's room. When entering the room, the odor became stronger and a bedside commode present in the room was full with feces and two bedside urinals were present both containing urine, one of which was full. Resident #3 requires assistance with bowel/bladder management, hygiene and with transfers. Per resident #3 interview, staff assisted at 5:15am when resident requested assistance, but the commode and urinals were still full at approximately 10:45am. Resident#3 reports that staff often do not clean the commode after a bowel movement and not emptying the urinal and has waited up to about 5 hours before a staff member would come to clean the commode.

Repeat Violation Date: 11/8/23 et al.

Plan of Correction

Accept () - 12/24/2024)

RCD or designee will complete in service with all staff on dignity and respect of residents by 1/15/24. Med techs will round at beginning and end of each shift daily moving forward to ensure all care staff have provided care as needed for residents. Med techs will sign off on assignment sheets indicating tasks have been completed. RCD and ARCD will review assignment sheets daily to ensure compliance. RCD, ARCD or designee will round weekly to ensure all resident rooms are clean and sanitary moving forward.

Licensee's Proposed Overall Completion Date: 01/15/2025

Implemented () - 02/11/2025)

65f - Training Topics

5. Requirements

2600.

65f - Training Topics (continued)

- 65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
 3. Care for residents with dementia and cognitive impairments.
 4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
 5. Personal care service needs of the resident.
 6. Safe management techniques.
 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2023.

Repeat Violation Date: 11/8/23 et al.

Plan of Correction

Accept (████) - 12/24/2024)

RCD or designee will review and in-service staff person B on missing training to ensure knowledge and understanding by 12/31/24. And will train topics annually to all direct care staff per PA reg 2600 65.f. RCD and BOM will review compliance with assigned training monthly beginning 12/31/24 and report any missing or in complete training by employees to ED moving forward. Department heads will ensure employees complete any missing trainings with in 14 days of reported incident.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented (████) - 02/11/2025)

65g - Annual Training Content

6. Requirements

2600.

- 65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
 3. Resident rights.
 4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
 5. Falls and accident prevention.
 6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2023 to December 2023.

Staff person D did not receive training in emergency preparedness procedures and recognition and response to crises

65g - Annual Training Content (continued)

and emergency situations, resident rights, the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), falls and accident prevention during training year January 2023 to December 2023.

Repeat Violation Date: 11/8/23 et al.

Plan of Correction

Accept (█) - 12/24/2024)

ED or designee will complete in-service training for missing training for staff person D by 12/31/24 Comprehensive training plan will be updated to include all requirements per PA reg 2600 65.g. ED and BOM will ensure yearly trainings are given as scheduled per the Yearly Training Schedule monthly on the last Thursday of the month at Town Hall Staff meetings. BOM will monitor Relias training completion monthly and report missing trainings to ED and department heads, employees will have 14 days to complete any identified missing trainings.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented (█) - 02/11/2025)

81b - Resident Personal Equipment**7. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #4 uses a bedside mobility device. The measurement between the bars was approximately 16 inches and was uncovered, created an entrapment risk.

Plan of Correction

Accept (█) - 12/24/2024)

Device was removed from Resident #4 bed. RCD, Maintenance director or designee will make weekly inspection of resident rooms beginning 12/10/24 and will continue moving forward to ensure no unsafe devices are in use. Nursing staff in-service begun 12/12/24 and will be completed by 12/31/24. Any use of bed mobility devices must be cleared by RCD or ED moving forward.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented (█) - 02/11/2025)

82a - Poisonous Materials**8. Requirements**

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 11/13 at 11 am., the housekeeper was observed spraying a clear liquid from a large unlabeled pressure spray bottle, in the memory care hallway. The clear liquid was not in the original container with correct label.

Plan of Correction

Accept (█) - 12/24/2024)

All chemicals outside of original containers have been discarded. Maintenance Director and RDC will in service all staff on requirement of keeping all poisonous materials in original containers started 12/12/24 will be completed 12/31/24 for all housekeeping staff. Housekeeping supervisor or designee will audit housekeeping carts daily and Maintenance Director will audit housekeeping carts weekly to ensure all chemicals being used are in original containers.

82a - Poisonous Materials (continued)

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/11/2025)

85a - Sanitary Conditions

9. Requirements

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/13/24 at 10:45 am, feces was observed in resident #3s commode chair, and the urinal was not emptied. The room had a strong feces odor. Resident indicated that the commode had not been cleaned in approximately 5 hours.

On 11/14/24 at 9:45 am, dried feces was observed on Resident #5's toilet seat.

Plan of Correction

Accept () - 12/24/2024)

Maintenance Director and RCD or designee will in service all staff on need for sanitary conditions to maintained at all times this will be completed by 12/31/24. Assigned housekeeper will audit rooms on assigned unit daily to ensure sanitary conditions are maintained. Maintenance director will perform monthly audits of resident room to ensure sanitary conditions are maintained moving forward,

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/11/2025)

95 - Furniture and Equipment

10. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 11/13/24 and on 11/14/24. The gate in the memory care courtyard has a chirping sound. Residents have been complaining about the inability to sleep because of the constant sound. On 10/24/24, an email was sent to corporate documenting the issue with the gate, and the home has not corrected the issue.

Plan of Correction

Accept () - 12/24/2024)

Memory care gate was repaired 11/19/2024 by company IT company and no beeping or chirping is now noted. ED and maintenance director will walk physical plant starting 12/10/24 twice weekly for 3 months, then starting 3/10/24 weekly for 3 months, then starting 6/10/24 bi-weekly for 3 months, then starting 9/10/24 monthly to ensure all furniture and equipment is in good working condition. Any broken or malfunctioning equipment will be repaired or replaced timely moving forward.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/11/2025)

103g - Storing Food

11. Requirements

2600.

103g - Storing Food (continued)

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

Description of Violation

On 11/14/24 at 11am, there was a bag of almonds, a package of active dry yeast, a bag of cheerios, and a box of baking soda in the food pantry that were all opened and unsealed.

Plan of Correction

Accept () - 12/24/2024)

All opened and unsealed food was discarded in real time. Dining service director or designee will in-service all kitchen staff regarding the need for all opened food to be labeled with date opened and sealed after use all in-servicing will be completed by 12/31/24. Dining service director or designee will audit food storage bi-weekly starting 12/12/24, then weekly starting 3/12/24 moving forward to ensure no unsealed opened or undated food.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/11/2025)

105g - Lint Removal and Duct Cleaning

12. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 11/14/24, there was an approximate 1 inch thick accumulation of lint in the lint trap of the 3rd floor dryer. There were no clothes in the dryer at the time.

Plan of Correction

Accept () - 12/24/2024)

Lint found in lint trap was immediately removed and discarded. Signage for removal of lint after dryer use in place as reminder. Med techs will inspect lint traps at start and end of each shift to ensure they are clean beginning 12/10/24 and moving forward. RCD or designee will in service staff on the need to remove all lint from lint trap in dryer after each use completed by 12/31/24

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/11/2025)

107b - Emergency Procedures

13. Requirements

2600.

107.b. The home shall have written emergency procedures that include the following:

- 4. Means of transportation in the event that relocation is required.

Description of Violation

The home's written emergency procedures have not updated their emergency shelter location. The home has a former assisted living facility listed as their only emergency shelter location, however this location closed in May 2024.

Plan of Correction

Accept () - 12/16/2024)

New shelter in place location has been established. Accelerate Willow Grove 3485 Davis Ville Rd Hatboro PA 19040 as of 12/13/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

107b - Emergency Procedures (continued)

Implemented () - 02/11/2025)

107c - Food/Water 3 Day Supply

14. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 11/14/24, the home served 69 residents, requiring 207 gallons of emergency drinking water. However, the home had only 108 gallons. The home does not have a contract with a local bottled water supplier that includes 24-hour service in case of emergency.

Repeat Violation Date: 11/08/23 et al.

Plan of Correction

Accept () - 12/16/2024)

The home had self-identified the violation and ordered the water on 11/12/2024 and showed the inspectors the order during the site inspection, the water arrived on 11/15/2024. The home currently is in compliance with the regulation. The Dining Service Director or designee will monitor 3-day supply of food and water monthly and ensure correct levels are maintained.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented () - 02/11/2025)

107d - Procedure Emergency Management Agency Submission

15. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to the local emergency management agency since 08/08/2023.

Plan of Correction

Accept () - 12/24/2024)

The written emergency procedures were reviewed 12/10/24, the plan was updated and submitted to the local emergency management agency by ED on 12/19/24 then annually and /or as needed to maintain compliance of 2600 107.d. ED will review plan during q 3month QI meetings beginning 12/17/24 and update plan as needed moving forward.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented () - 02/13/2025)

141b1 - Annual Medical Evaluation

16. Requirements

2600.

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

141b1 - Annual Medical Evaluation (continued)

Description of Violation

Resident #6's most recent medical evaluation was completed on [REDACTED]. The resident's previous medical evaluation was completed on [REDACTED].

Plan of Correction

Accept ([REDACTED]) - 12/24/2024)

RCD conducted audit of all current residents' medical evaluations to ensure compliance with date as of 12/10/24 and will review monthly to ensure compliance moving forward. Tickler file was created and will be reviewed weekly by RCD, ARCD and night LPN moving forward to ensure compliance. In-service begun 12/12/24 and will be completed by 12/31/24 for nursing staff.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([REDACTED]) - 02/11/2025)

144c1 - Smoking Area Guidelines

17. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area does not have cushions that are fireproof. Tags were inspected for the fire-resistant label and cushions are not considered fire-resistant.

Plan of Correction

Accept ([REDACTED]) - 12/24/2024)

Cushions were removed from smoking area. No cushions will be placed on furniture in designated smoking areas moving forward. Maintenance Director will monitor smoking area weekly starting 12/10/24 and ongoing to ensure no cushions were placed on furniture, furniture in smoking area is metal no cushions are needed. Regulatory requirement for cushions per regulation 144.c were reviewed with Maintenance director by ED on 11/14/24

Licensee's Proposed Overall Completion Date: 12/21/2024

Implemented ([REDACTED]) - 02/11/2025)

144d - Smoking Outside

18. Requirements

2600.

144.d. Smoking outside of the smoking room is prohibited.

Description of Violation

On 11/13/24 at 1:45pm, a resident was smoking in front of the home and within 3 feet of the front entrance which is not the home's designated smoking area. The home's designated smoking area is in the back of the home 15 feet away from the home.

Plan of Correction

Accept ([REDACTED]) - 12/24/2024)

ED or designee will review community smoking policy with residents and ensure residents are aware of designated smoking areas completed by 12/31/24. ED will in-service staff on smoking policies and areas by 12/31/24. No

144d - Smoking Outside (continued)

smoking signs hung outside main entrance. Staff will monitor and report any issues to ED or supervisor.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([redacted] - 02/11/2025)

234b - Support Plan Needs Elements

19. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan dated [redacted], for resident #4 does not address the use of a bedside mobility device. Resident#5 was not accessed for mobility and the proper use of an enabler.

The support plan, dated [redacted] for resident #7 does not address turning and positioning in bed/chair. Per support plan, staff member will assist with repositioning as needed. Resident#7's medical evaluation dated [redacted] has an order for turn and positioning every 2 hours.

Plan of Correction

Accept ([redacted] - 12/24/2024)

Support plan was corrected to reflect q 2 hour turn and repositioning. RCD conducted audit of support plans and medical evaluations to ensure all orders are addressed correctly on support plans on 12/10/24. RCD and ARCD will review new DME's and RASP's monthly starting 12/12/24 to ensure all information is correct moving forward.

Licensee's Proposed Overall Completion Date: 12/21/2024

Implemented ([redacted] - 02/11/2025)