

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

February 13, 2025

[REDACTED], PERSONAL CARE ADMINISTRATOR
HUMANGOOD PENNSYLVANIA

RE: THE MANSION AT ROSEMONT
404 CHESWICK PLACE
ROSEMONT, PA, 19010
LICENSE/COC#: 17663

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/11/2024, 12/12/2024 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: *THE MANSION AT ROSEMONT* License #: *17663* License Expiration: *06/07/2025*
 Address: *404 CHESWICK PLACE, ROSEMONT, PA 19010*
 County: *DELAWARE* Region: *SOUTHEAST*

Administrator

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

Legal Entity

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

Certificate(s) of Occupancy

Type: *I-1* Date: *03/23/2023* Issued By: *Radnor Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *101* Waking Staff: *76*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *12/12/2024*

Inspection Dates and Department Representative

12/11/2024 - On-Site: [Redacted]
 12/12/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *221* Residents Served: *76*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Memory Support* Capacity: *18* Residents Served: *15*

Hospice
 Current Residents: *0*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *76*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

12/11/2024 - Full
 Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *01/24/2025*

Inspections / Reviews (*continued*)

01/29/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/12/2025

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 02/03/2025

02/06/2025 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/12/2025

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 02/14/2025

02/13/2025 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/12/2025

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 10-12-24, Evinity 105mg/1.17ml, prescribed for resident #1 once per month, was not available in the home. The resident did not receive the medication for the month of October. The home did not report this medication error to the department.

Plan of Correction

Directed (████) - 02/06/2025)

The Personal Care Administrator will in-service nursing team members of the policy and procedure for missed medication administration and reportable incident regulation to ensure timely reporting to DHS on the week of 1/27/25. The Personal Care manager or designee will read nursing notes and community incident reports daily M-F. Audits have been implemented since 1/27/2025. The personal Care Administrator or designee will audit records weekly for compliance and report findings monthly at QAPI for the next 3 months or longer if compliance is not maintained. next QAPI 2/11/25

Directed Completion Date: 02/11/2025

Implemented (████) - 02/13/2025)

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

On 12-11-24, two contractors completing renovations in the home were observed unsupervised in room #1. The home did not have criminal background checks for these contractors.

Plan of Correction

Accept (████) - 02/06/2025)

The director of Buildings and Grounds or designee will notify outside construction vendors and contractors to provide approved criminal background checks through PATCH the week of 1/27/25. Moving forward, our Director of Buildings and Grounds and our general contractor will ensure a background check, or a supervision plan is in place for the contractor before beginning work. The director of Buildings and Grounds, starting 2/3/25, will conduct random bi-weekly audits and report findings to monthly QA. for the next 3 months or longer if compliance is not maintained. Next QAPI 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (████) - 02/13/2025)

65f - Training Topics

3. Requirements

65f - Training Topics (*continued*)

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
6. Safe management techniques.

Description of Violation

Direct care staff person A and B did not receive training the following during training year 2023:

- *Meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan*
- *Safe management techniques*

Repeat violation: 11-27-23 et al.

Plan of Correction**Directed (█ - 02/06/2025)**

The personal Care Administrator will in-service staff A and B on meeting residents' needs and safe management techniques during the week of 1/27/25-2/3/2025. The Human Resources Manager and/or the designee will complete monthly in-person annual training. The Personal Care Administrator will conduct quarterly audits starting 2/3/25 of the training and report to monthly QA for the next three quarters or longer if compliance is not maintained. QA schedule for 2/11/25

Directed Completion Date: 02/11/2025

Implemented (█ - 02/13/2025)

65g - Annual Training Content

4. 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.
3. Resident rights.

Description of Violation

Staff person A did not receive training in fire safety and resident rights during training year 2023.

Repeat violation: 11-27-23 et al.

Plan of Correction**Accept (█ - 02/06/2025)**

Staff person A received live fire safety and resident rights training from Human Resources and the Executive Director on 1/28/2025. Starting the week of 1/27/25, the Human Resources Manager and/or designees will complete in-person annual staff training monthly. Personal Care Administrator will conduct quarterly audits of the training and report to monthly QA for the next three Quarters or longer if compliance is not maintained. QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (█ - 02/13/2025)

85a - Sanitary Conditions

5. Requirements

85a - Sanitary Conditions (continued)

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

The following unsanitary conditions were observed on 12-11-24:

- *At 9:38am, the refrigerator and freezer had spills and stains from food spills located on the lobby level of the home in the 100 area.*
- *At 9:45am, the vent in the common area bathroom located near the laundry room had an accumulation of dust.*

Plan of Correction

Accept (█) - 02/06/2025)

Housekeeping cleaned areas on the day of inspection. Starting 2/3/25, the housekeeping manager will complete common kitchen and bathroom audits weekly to ensure sanitary conditions are maintained. The findings will be reported to monthly QA for three months or longer if compliance is not maintained. QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (█) - 02/13/2025)

88a - Surfaces

6. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 12-11-24 at 9:58 am, exit stairwell #6 in the home had the following concerns:

- *several small pin sized black spots in close proximity covered the stairwell walls.*
- *A pipe above the exit door showed brown stains near the opening of the pipe on the outer perimeter.*

On 12-12-24 at 1:34pm the following concern was observed in the Memory support unit:

- *A missing ceiling tile exposed red and blue wires.*

Plan of Correction

Accept (█) - 01/29/2025)

On the inspection day, the building and grounds director cleaned stairwell #6. Work was currently being completed in the area of the missing tile, which was replaced on the day of the inspection. Moving forward, the director of grounds or designee will conduct weekly community rounds to ensure that stairwells and exit doors are free from stains. Starting the week of 1/27/25, the director of Grounds or Designee will conduct weekly community rounds to ensure the ceilings tiles are in place. The director of grounds or designee will report to monthly QA. for three months or longer if compliance is not maintained.

Licensee's Proposed Overall Completion Date: 02/07/2025

Implemented (█) - 02/13/2025)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

103f - Refrigerator/Freezer Temps (*continued*)**Description of Violation**

There was no thermometer in the refrigerator and freezer in the kitchenette area located on the lobby level area of the home.

Plan of Correction

Directed (█) - 02/06/2025)

The thermometer was placed in the refrigerator on the day of inspection. The week of 2/3/2025, The housekeeping Manager will in-service the housekeeping team on the regulations for refrigeration temperatures. Starting 2/3/25, the common areas' refrigerators of personal care will be checked for refrigerator temperature and documented on the daily refrigerator log. The results of the log Will be reported to monthly QA for three months or longer if compliance is not maintained. QA 2/11/25

Proposed Overall Completion Date: 02/11/2025

Directed Plan of Correction:

To clarify the above plan, the housekeeping manager shall performed the above audits of the refrigerators/freezers and document the log.

Directed Completion Date: 02/11/2025

Implemented (█) - 02/13/2025)

185a - Implement Storage Procedures

8. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #3 is prescribed blood glucose readings 4 times per day. On 12/11/24 the following transcription errors are present:

- o 9:15am – 253 shows on glucometer while the MAR documents 160 at 8am*
- o 11:12am – 251 shows on glucometer while the MAR documents exception code 1 – absent from home*
- o 6:33pm – 252 shows on the glucometer while the MAR documents 187 at 5pm*
- o 8:54pm - 246 shows on the glucometer while the MAR documents 248 at 8:30pm*

Plan of Correction

Accept (█) - 02/06/2025)

On the week of 1/27/25, the Personal Care Administrator will re-educate the Licensed Nurses and medication technicians on proper documentation of glucometer reading results. Starting 2/3/25, The Personal Care Manager or designee will complete weekly glucometer audits for discrepancies and report to QA for the next three months or longer if they are not in compliance. QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (█) - 02/13/2025)

185b - Medication Procedures

9. Requirements

185b - Medication Procedures (continued)

2600.

185.b. At a minimum, the procedures must include:

4. Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.

Description of Violation

The home's procedures for the safe use of medications and medical equipment do not include a policy for the use of Continuous Blood Glucose Monitoring Systems.

Plan of Correction**Accept (█) - 02/06/2025)**

The personal care administrator will review the Continuous Blood Glucose Monitoring System policy with the Licensed Nurses and Certified Diabetic Trained Med Techs during the week of 2/3/25. Additionally, a copy of this policy has been printed and distributed to each care base for ease of access as of 2/3/2025.

Again, with respect, we request withdrawal of this violation. A policy was not requested but is part of our standard operating policies.

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (█) - 02/13/2025)**187d - Follow Prescriber's Orders****10. Requirements**

2600.

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

Description of Violation

Resident # 3 is on a sliding scale which has parameters that read as follows: blood sugar levels ranging from 0-179= 0 units of insulin, 180-249 = 2 units of insulin, 241-300=4units of insulin , 301-350= 6 units of insulin, 351-400 = 8 units of insulin. The prescribers orders were not followed on the following days.

- *On 12-5-24 at 3:01pm the glucometer reading was 263, which required 4 units of insulin. The home documented the medication administration record with a reading of 233 and 2 units of insulin were administered.*
- *On 12-7-24 at 3:19pm the glucometer reading was 251 requiring 4 units of insulin. The home documented the medication administration record with a reading of 229, the home administered 2 units of insulin*

Repeat violation: 11-27-23 et al.

Plan of Correction**Accept (█) - 02/06/2025)**

On the week of 1/27/25, the personal Care Administrator will re-educate the med techs who are diabetic-trained, certified, and LPNs on proper documentation of glucometer reading results. Starting 2/3/25, The Personal Care Manager or designee will complete weekly glucometer audits to check for MAR/Glucometer/insulin dose discrepancy and report to QA for the next three months or longer if not in compliance. QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented (█) - 02/13/2025)

187d - Follow Prescriber's Orders (continued)

11. Requirements

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

Description of Violation

Resident #1 is prescribed Evinity 105mg/1.17 ml once monthly. However, this medication was not administered to resident #1 in October 2024 because the medication was not available in the home.

Repeat violation: 11-27-23 et al.

Plan of Correction

Accept () - 02/06/2025

The Personal Care Administrator will re-educate the med techs and LPNs on medication policy and procedure for medication availability. Starting 2/3/25, The personal Care manager will conduct monthly cart audits to ensure the availability of prescribed medications for the next three months or longer if they are not in compliance. Will report to QA, Next QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented () - 02/13/2025

188b - Medication Error Reporting

12. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident #1 is prescribed Evinity 105mg/1.17ml once monthly. However, resident #1 was not administered the medication during the month of December 2024. The medication error was not reported to the resident's designated person or the prescriber.

Plan of Correction

Accept () - 02/06/2025

On the week of 1/27/25, The Personal Care Administrator will in-service the med tech and LPNs on the policy and procedure for missed medication reporting to ensure immediate reporting to the resident, resident designated person, and prescriber on the week of 1/27/25. The Personal Care manager or designee will review MAR missed meds and reconcile them against nurses' notes to ensure proper protocol daily M-F. The personal Care Administrator or designee will track and report findings to monthly QA starting 2/3/25 for compliance and report findings monthly at QAPI for the next 3 months or longer if compliance is not maintained. Next QA 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented () - 02/13/2025

236 - Staff Training

13. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

236 - Staff Training (continued)

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) had only 2 hours of annual training in dementia care during the 2023 training year.

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU) had only 3 hours of annual training in dementia care during the 2023 training year.

Plan of Correction

Accept ([redacted] - 02/06/2025)

The Personal Care Administrator will re-educate Staff Person A and Staff B on dementia training on or before 2/19/2025 via group session or individually based on their schedule. The Human Resources manager and/or designees will complete monthly in-person annual staff training moving forward starting on 1/29/25. Starting 2/3/25 Human resources will report monthly training completion audits to QA for the next six months or longer if compliance is not maintained. QA date is 2/11/25

Licensee's Proposed Overall Completion Date: 02/11/2025

Implemented ([redacted] - 02/13/2025)