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

February 4, 2025

[redacted]
470 MANOR OPERATING LLC
[redacted]

RE: ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING
490 MANOR AVENUE
DOWNINGTOWN, PA, 19335
LICENSE/COC#: 14108

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/19/2024 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: *ST. MARTHA VILLA FOR INDEPENDENT & RETIREMENT LIVING* **License #**: *14108* **License Expiration**: *06/08/2024*

Address: *490 MANOR AVENUE, DOWNINGTOWN, PA 19335*

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

Administrator

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

Legal Entity

Name: *470 MANOR OPERATING LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *11/25/2002* **Issued By**: *CWOPA L & I*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *152* **Waking Staff**: *114*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *12/19/2024*

Inspection Dates and Department Representative

12/19/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served**: *99*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *30* **Residents Served**: *24*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *99*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *53* **Have Physical Disability**: *0*

Inspections / Reviews

12/19/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/16/2025*

01/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/16/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/02/2025*

Inspections / Reviews *(continued)*

02/04/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/31/2025*

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

17 - Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] at 2:40 pm, the medication cart was unlocked, unattended, and accessible on the 3rd floor, outside of the medication office.

Repeat violation: [redacted], [redacted] et al

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

17 Record Confidentiality
2600
1. Medication Cart was locked 12/19/2024 by clinical director.
2. All medication carts were checked by the clinical director on 12/19/2024 and were locked.
3. Clinical Director or designee educated the clinical team on the importance of locking medication and treatment carts on or before 1/24/2025.
4. Clinical Director or designee will complete a weekly audit of medication carts to insure they are locked when not in use. The audit will be conducted once a week for a month. The audit results will be review at the facility QAPI meeting on or before 1/31/2025

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

65a - FS Orientation 1st Day

2. 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 A, whose first day of work was [redacted], did not receive orientation on the following topics: evacuation

65a FS Orientation 1st Day (continued)

procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person B, whose first day of work was 6/2/2024, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Staff person C, whose first day of work was 11/30/2024, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Repeat violation: 4/29/2024

Plan of Correction ***Accept [redacted] - 01/16/2025)***

65a
1. Employees A,B,C if still employed to the facility were reoriented on general fire safety and emergency preparedness on or before 1/31/2025.
2. Employees hired in the last 90 days who are still employed had their personal file checked by HR manager to ensure general fire safety and emergency preparedness training was completed on or before 1/31/2025.
3. Clinical Director or designee educated staff on the importance general fire safety and emergency preparedness on or before 1/31/2025.
4. Clinical Director or designee will complete an audit of new hire employees' files to ensure they have been trained on general fire safety and emergency preparedness. The audit will be conducted once a week for a month. The audit results will be review at the facility QAPI meeting on or before 1/31/2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented ([redacted] - 02/03/2025)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

101j7 - Lighting/Operable Lamp (continued)

Resident [redacted] does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

101j7
1. Resident[redacted] and [redacted] had lighting placed next to the bedside by the maintenance director on or before 1/31/2025.
2. All resident rooms were checked to ensure sure they have a light next to the bed by the maintenance director on or before 1/31/2025.
3. Administrator or designee educated the maintenance department on the importance of residents having light at the bedside on or before 1/31/2025.
4. Maintenance director or designee will complete an audit of bedside light to ensure they are in place. The audit will be conducted once a week for a month. The audit results will be review at the facility QAPI meeting on or before 1/31/2025.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

141b1 - Annual Medical Evaluation

4. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

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

Repeat violation: 4/29/2024

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

141b1
1. Resident's medical evaluation from 2022 could not be retroactively corrected by the physician on or by 1/31/2025.
2. Clinical Director reviewed all medical evaluations for completion dates for the last years. If medical evaluations are required due the physicians were made aware. If past medical evaluations could not retroactively completed, they were identified through an audited item that could not be completed by the Clinical Director on or before 1/31/2025.
3. Administrator or designee educated the Clinical Director on the importance on providers completing.
4.Clinical Director or designee will complete an audit of medical evaluations to ensure they are completed timely. The audit will be conducted once a week for a month. The audit results will be review at the facility QAPI meeting on or before 1/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

183e - Storing Medications

5. Requirements

183e Storing Medications *(continued)*

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On [redacted]:

- *an [redacted], prescribed to resident [redacted] was on the medication cart with an open date of [redacted]. According to the manufacturer's instructions the medication should be discarded 28 days after opening.*
- *[redacted], prescribed to resident [redacted] were on the medication cart with an open date of [redacted]. According to the manufacturer's instructions the medication should be discarded 4 weeks after opening.*

Repeat violation: 4/29/2024, 7/31/2024 et al

Plan of Correction ***Accept [redacted] - 01/16/2025)***

183e
1. [redacted] was discarded by the clinical director on [redacted] for resident number four. Clinical Director reordered [redacted] for resident number five on [redacted]
2. Clinical director or designee checked all insulin pens on or before 1/16/2025 and none were outdated. In addition, the clinical director checked all eyedrops that had a four-week discard date and none were a concern as of 1/16/2025.
3. Med techs and nurses were educated on the importance of managing medications per expiration or discard dates by the clinical Director on or before January 31, 2025.
4. The clinical Director will audit medication cards to ensure meds are removed if expired or have met their discard date by the manufacturer. The audit will be completed once a week for 30 days. The results of the audit will be reviewed during the facility qapi meeting.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented ([redacted] - 02/03/2025)

185a Implement Storage Procedures

6. 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

On [redacted] at 3:00 pm, resident [redacted] indicated the date and time as [redacted], 2:03 pm.

On the following dates and times, glucose readings were incorrectly documented in resident [redacted] December 2024 medication administration record (MAR):

- *[redacted], 11:48 am: [redacted] reading [redacted] documented in MAR as [redacted]*
- *[redacted], 11:37 am: [redacted] reading [redacted] documented in MAR as [redacted]*

185a Implement Storage Procedures (continued)

Repeat violation: [redacted] *et al*

Plan of Correction ***Accept*** [redacted] ***01/16/2025)***

185.a.
1. Resident [redacted] *glucometer reading could not be retroactively corrected by the clinical Director on* [redacted].
2. Clinical director or designee checked all glucometers to ensure blood sugar readings were indicated on or before 1/16/2025 for blood sugars taken from 1/1/2025 to 1/15/2025. If the glucose reading did not match the MAR with glucometer the MD was made aware on or before 1/16/2025.
3. Clinical Director educated the clinical team on the importance taking blood sugars with the glucometer and documenting on the MAR on or before 1/31/2025.
4. Clinical director or designee will audit glucometer to ensure a blood sugar reading is accurate in the MAR. The audit will be conducted once a week for 30 days. The results of the audit will be reviewed during the facility. Qapi meeting.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] ***- 02/03/2025)***

187d - Follow Prescriber's Orders

7. Requirements

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

Description of Violation

Resident [redacted] *is prescribed* [redacted], *subcutaneously before meals per sliding scale. On* [redacted] *at 11:00 am, there is no glucose reading in the resident's glucometer, however, a reading of* [redacted] *was documented in the resident's medication administration record (MAR).*

Plan of Correction ***Accept (*** [redacted] ***01/16/2025)***

187.d.
1. Resident [redacted] *glucometer reading could be retroactively corrected by the clinical Director on 12/19/2024.*
2. Clinical director or designee checked all glucometer to ensure blood sugar readings were indicated on or before 1/16/2025 for blood sugars taken from 1/1/2025 to 1/15/2025. If the glucose reading did not match the MAR with glucometer the MD was made aware on or before 1/16/2025.
3. Clinical Director educated the clinical team on the importance taking blood sugars with the glucometer and documenting on the MAR on or before 1/31/2025.
4. Clinical director or designee will audit glucometer to ensure a blood sugar reading is accurate in the MAR. The audit will be conducted once a week for 30 days. The results of the audit will be reviewed during the facility. Qapi meeting

187d - Follow Prescriber's Orders (continued)

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

190b - Insulin Injections

8. Requirements

2600.
190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

Description of Violation

On [redacted] and [redacted] at 8:00 pm, staff person D, who has not successfully completed a Department-approved [redacted] patient education program with in the last 12 months, administered [redacted] to resident [redacted]

Repeat violation: [redacted]

Plan of Correction ***Accept ([redacted] 01/16/2025)***

190.b

1. Clinical director ensured Staff member D completed diabetic patient education program on or before 1/15/2025 by an approved organization.

2. Clinical Director reviewed all personnel files for staff members who are to complete diabetic patient education program on or before 1/15/2025. All staff members had the approved education.

3. Administrator educated the clinical director on the importance of staff completing the diabetic patient education program on or before 1/31/2025.

4. Clinical director will complete an audit on all med tech education files to ensure the staff had up-to-date diabetic patient education training. The audit will be completed once a week for 30 days. The audit results will be reviewed during the facility qapi meeting.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

225c - Additional Assessment

9. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident [redacted] current assessment was completed on [redacted] However, the resident's previous assessment was completed on [redacted]

225c - Additional Assessment (continued)

Repeat violation [redacted] et al

Plan of Correction ***Accept [redacted] - 01/16/2025)***

225c.
1. Resident [redacted] assessment could not be retroactively corrected by the clinical director on 12/19/2024.
2. Clinical Director completed an evaluation of all assessments for residents. If the clinical director could update the current assessment, assessment was updated. If assessments could not be retroactively corrected a note was written in the chart on or before 1/31/2025.
3.Clinical director was educated by the administrator on the importance of completing assessments in a timely manner owner before 1/31/2025
4.Clinical Director or designee will complete and audit on all assessments to ensure that they are completed timely. The order will be completed once a week for one month. The results of the audit will be reviewed during the facility qapi meeting.

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

231c - Preadmission Screening

10. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident [redacted]s written [redacted] screening was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 01/16/2025)***

231c
1. Resident number [redacted] prescreen could not be retroactively corrected by the clinical director by 12/19/2025.
2. Clinical Director reviewed prescreen documentation and updated prescreens if they could be updated. If prescreen could not be retroactively corrected a note was written in the chart on or before 1/31/2025.
3. Administrator educated the clinical Director on the importance of having prescreens completed timely on or by January 31, 2025.
4. Clinical Director will complete an audit of prescreens once a a week for one month to ensure they are completed. The results of the order will be reviewed at the facility qapi meeting.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

231e - No Objection Statement

11. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident [redacted] was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Accept [redacted] - 01/16/2025)***

231e
1.Admissions director ensured Resident [redacted] had a signed 'No objection Statement' by 1/16/2025.
2.Admissions director reviewed all objection statements for residents on the secured dementia unit. All Statement are signed as of 1/16/2025.
3.Admissions Director was educated on the importance of having a no objection statement in memory care dementia unit paperwork. Admissions director was educated by the administration owner before 1/16/2025.
4.Admissions Director will audit dementia Care resident financial charts to ensure the "no objection states are completed. The audit will be completed once a week for one month. The results of the audit will be reviewed at the facility qapi meeting

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/03/2025)

231f - Assessed Annually

12. Requirements

2600.
231.f. In addition to the requirements in § 2600.225 (relating to initial and annual assessment), the resident shall also be assessed annually for the continuing need for the secured dementia care unit.

Description of Violation

Resident [redacted] was assessed for the need for Secure Dementia Care Unit (SDCU) on [redacted] and was not assessed again in 2024.

Plan of Correction ***Accept [redacted] - 01/16/2025)***

231f
Resident [redacted] had a 2024 DME completed on 7/15/2024 by a provider and verified completed by the administrator on January 16, 2025.
Clinical Director reviewed DME documentation and had a Provider updated the DME if required. If DME could not be retroactively corrected a note was written in the chart on or before 1/31/2025.
administrator educated the clinical director on importance of having DME's completed timely on or before 1/31/2025.
Clinical Director will complete an audit of all DME to ensure they are completed timely. The audit will be completed once a a week for one month. The results of the audit will be reviewed during the facility qapi meeting.
Thank You,

Proposed Overall Completion Date: 01/31/2025

231f Assessed Annually *(continued)*

Licensee's Proposed Overall Completion Date: *01/31/2025*

Implemented [redacted] - 02/04/2025)