

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

March 3, 2025

[REDACTED]
ACCOLADES SENIOR CARE LLC
[REDACTED]
[REDACTED]

RE: ACCOLADES SENIOR CARE
246 MELROSE AVENUE
EAST LANSDOWNE, PA, 19050
LICENSE/COC#: 13571

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/15/2025 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: ACCOLADES SENIOR CARE License #: 13571 License Expiration: 04/25/2025
 Address: 246 MELROSE AVENUE, EAST LANSDOWNE, PA 19050
 County: DELAWARE Region: SOUTHEAST

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: ACCOLADES SENIOR CARE LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 04/09/2001 Issued By: CWOPA L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 30 Waking Staff: 23

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Monitoring Exit Conference Date: 01/15/2025

Inspection Dates and Department Representative

01/15/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 45 Residents Served: 29
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 1
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 29
 Diagnosed with Mental Illness: 29 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 1 Have Physical Disability: 1

Inspections / Reviews

01/15/2025 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/07/2025

02/10/2025 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 02/20/2025
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 02/15/2025

Inspections / Reviews *(continued)*

02/18/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/20/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 02/21/2025

03/03/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/20/2025

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 [REDACTED] resident [REDACTED] passed away in the home. The home did not submit an incident report to the Department. The home did not report this incident to the department until [REDACTED].

Repeat violation: [REDACTED]

Plan of Correction

Accept [REDACTED] - 02/18/2025)

The resident in question was placed on Hospice on 10/20/23 after [REDACTED] returned home from being hospitalized. The home is aware that there is a 24 hour window to report all reportable incidents. The administrator and the assistant administrator met to discuss who will be responsible for completing the reportable incident paper work when an incident occurs and submit it. It was decided that the designated staff, [REDACTED] will complete all reportable incidents and if [REDACTED] is absent, then the Administrator, [REDACTED] will complete it. When an incident occurs, the staff person who is in charge will complete the in house reportable incident sheet noting the date, time, initial, incident, was administrator notified, was incident reported to the state. The administrator and designated staff will review and submit reportable incident to the state within 24 hours.

Proposed Overall Completion Date: 02/14/2025

Licensee's Proposed Overall Completion Date: 02/14/2025

Implemented [REDACTED] - 03/03/2025)

132c - Fire Drill Records

3. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on [REDACTED] does not include exit route used.

Plan of Correction

Accept [REDACTED] - 02/10/2025)

After each fire drill, the Administrator, [REDACTED] will audit the fire drill book using the monthly fire log Audit sheet to make sure that all areas in the log have been fully completed. [REDACTED] will complete the log immediately after the fire drill and will make any corrections and will sign the log. (Monthly Fire Log Audit Attached)

Proposed Overall Completion Date: 02/06/2025

Licensee's Proposed Overall Completion Date: 02/06/2025

Implemented [REDACTED] - 03/03/2025)

141a 1-10 Medical Evaluation Information

4. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

The resident [redacted] medical evaluation completed on [redacted] did not include special health or dietary needs of the resident.

Repeat violation: [redacted]

Plan of Correction

Accept [redacted] - 02/10/2025)

The resident in question’s DME was sent back out to the physician so that they could complete the missing dietary needs section. All residents files will be audited by two persons to ensure completeness. The administrator, Pansy Clarke will complete an initial audit of the resident’s file monthly and the designated staff, Nadine Campbell will do a follow up chart check immediately after and initial the log

Proposed Overall Completion Date: 02/06/2025

Licensee's Proposed Overall Completion Date: 02/06/2025

Implemented [redacted] - 03/03/2025)

183d Prescription Current

5. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [redacted] there was an unlabeled box of [redacted] that expired 4/2024 and two unlabeled tubes of [redacted] that expired [redacted] in the M-Z medication cart and a bottle of unopened liquid Children’s Pain Relief medication in the overflow medication closet. No resident in the home is prescribed these medications.

An unlabeled box of Imodium that expired [redacted] that belonged to staff member B was in the M-Z medication cart in a bottom drawer with resident medications.

In the home’s overflow medication storage closet, there was a bottle of [redacted] that belonged to resident [redacted] who passed away on [redacted] and a bottle of [redacted] that expired [redacted] belonging to resident 3 who passed away [redacted]

183d - Prescription Current (continued)

Plan of Correction**Directed** [REDACTED] - 02/18/2025)

On 1/15/25, the administrator met with staff B to inform that [REDACTED] is not allowed to store [REDACTED] medications here at the home. Expired and discontinued Medications that does not belong on the cart or in the home will be removed and stored in the locked medication cart that is not in use and will be sent back to the pharmacy when they visit the home. The homes medication closet was emptied out and all medications were sent back to the pharmacy. . The medication carts and medication closet will be checked daily by medication Tech who is on the cart for the day, the Administrator, [REDACTED] and the designated staff, [REDACTED] for expired and OTC medications. Expired and discharged residents Medications will be removed and sent back to the pharmacy when they visit the home. The pharmacy makes visit to the home monthly and when they are called for medication change or medication refills. The expired medications will be removed from the medication cart and stored in an old locked medication cart that is not in use. The staff will sign the log when the pharmacy picks up the returned medications.

Proposed Overall Completion Date: 02/06/2025

Proposed Overall Completion Date: 02/14/2025

Directed POC:

It is not acceptable to store discontinued and expired medications in the home.

Immediately: A designee qualified to administer medications shall complete an initial and monthly audit of the medication carts, first aid kits and any other medication storage areas to ensure there are no expired or discontinued medications. Any expired or discontinued medications shall be immediately discarded in accordance with the Department of Environmental Protection and Federal and State regulations. This includes prescription medications, OTC medications and CAM. Documentation shall be kept for review by the Department.

Directed Completion Date: 02/20/2025

Implemented [REDACTED] 03/03/2025)

183e - Storing Medications

6. Requirements

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] in the home's overflow medication storage closet there was a bottle of [REDACTED] for resident [REDACTED] that expired [REDACTED], and a bottle of Loperamide for resident [REDACTED] that expired [REDACTED]

There was a loose orange pill on counter in the overflow medication storage closet.

Repeat violation: [REDACTED]

183e - Storing Medications (continued)

Plan of Correction**Directed** [REDACTED] - 02/18/2025)

The homes medication closet was emptied out and all medications was sent back to the pharmacy. . The medication carts and medication closet will be checked daily by medication Tech who is on the cart for the day, the Administrator, [REDACTED] and the designated staff, [REDACTED] for expired and OTC medications. Expired and and discharged residents Medications will be removed and sent back to the pharmacy when they visit the home. The pharmacy makes visit to the home monthly and when they are called for medication change or medication refills. The expired medications will be removed from the medication cart and stored in an old locked medication cart that is not in use. The staff will sign the log when the pharmacy picks up the returned medications.

Proposed Overall Completion Date: 02/14/2025

Directed POC:

It is not acceptable to store discontinued and expired medications in the home.

Immediately: A designee qualified to administer medications shall complete an initial and monthly audit of the medication carts, first aid kits and any other medication storage areas to ensure there are no expired or discontinued medications. Any expired or discontinued medications shall be immediately discarded in accordance with the Department of Environmental Protection and Federal and State regulations. This includes prescription medications, OTC medications and CAM. Documentation shall be kept for review by the Department.

Directed Completion Date: 02/20/2025

Implemented [REDACTED] - 03/03/2025)

187a - Medication Record

7. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

187a Medication Record (continued)

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] and [REDACTED]. However, resident [REDACTED] medication administration record does not indicate diagnosis or purpose for these medications, including pro re nata (PRN).

Plan of Correction**Directed ([REDACTED] - 02/18/2025)**

On [REDACTED] The Administrator, [REDACTED] went over all the MARS and made sure that all medication ordered have the correct diagnosis written on them. On February 7, 2025, the pharmacy was contacted and the person who is responsible for printing the MARS has agreed that [REDACTED] will check the MARS thoroughly to make sure that all medications have the correct diagnosis written on them before printing. The medication tech for the morning day shift, the administrator, [REDACTED] and the designated staff, [REDACTED] will check the MARS after monthly RECAPS are completed to make sure that all medications have a diagnosis before Monthly cart checks. After review,

Proposed Overall Completion Date: 02/14/2025

Directed Completion Date: 02/14/2025

Implemented [REDACTED] - 03/03/2025)