Department of Human Services
Bureau of Human Service Licensing

May 3, 2021

[REDACTED] ED
SNH PENN TENANT LLC
400 CENTRE STREET
ATTN LICENSING
NEWTON, MA 2458

RE: EXTON SENIOR LIVING
600 NORTH POTTSTOWN PIKE
EXTON, PA, 19341
LICENSE/COC#: 14510

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/08/2021, 03/09/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *EXTON SENIOR LIVING* **Licen e #**: *14510* **Licen e Expiration Date**: *01/01/2022*
Addre : *600 NORTH POTTSTOWN PIKE, EXTON, PA 19341*
County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

Name: [redacted] **Phone**: *6105940200* **Email**: [redacted]

Legal Entity

Name: *SNH PENN TENANT LLC*
Address: *400 CENTRE STREET, ATTN LICENSING, NEWTON, MA, 2458*
Phone: *6105940200* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/03/2000* **Issued By**: *L&I*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *82* **Waking Staff**: *62*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *03/09/2021*

Inspection Dates and Department Representative

03/08/2021 - On-Site: [redacted]
03/09/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *55*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *BTR* **Capacity**: *32* **Residents Served**: *19*

Hospice

Current Re ident : *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *55*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *27* **Have Physical Disability**: *0*

Inspections / Reviews

03/08/2021 - Full

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *03/27/2021*

3/29/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/31/2021*

4/1/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/30/2021*

5/3/2021 - Document Submission

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

51 - Criminal Background Check

1. **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 Repeat Violation

Staff A was hired on [redacted] but the criminal background check was requested on [redacted] Staff B was hired on [redacted] but the criminal background check was requested on [redacted]

Repeated Violation: 10/06/2020

Plan of Correction **Accept**

Through ongoing audits from 10-6-2020 violation ED identified CBC on staff B not completed timely. Business Office manager was placed on Performance Improvement Plan after 10-6-2020 violation. Business Office Manager terminated [redacted] following discovery of continued non compliance with company policy and state regulations. A thorough audit of all personnel files was completed by the interim Business Office Manager 1/7/2021 and any background checks for current personnel were completed and files brought to compliance. Newly hired Business Office Manager will utilize a new hire checklist to maintain compliance with pre-hire requirements. Ed/designee will review and confirm CBC prior to start of employment.

Completion Date: *04/10/2021*

Document Submission **Implemented**

Through ongoing audits from 10-6-2020 violation ED identified CBC on staff B not completed timely. Business Office manager was placed on Performance Improvement Plan after 10-6-2020 violation. Business Office Manager terminated [redacted] following discovery of continued non compliance with company policy and state regulations. A thorough audit of all personnel files was completed by the interim Business Office Manager 1/7/2021 and any background checks for current personnel were completed and files brought to compliance. Newly hired Business Office Manager will utilize a new hire checklist to maintain compliance with pre-hire requirements. Ed/designee will review and confirm CBC prior to start of employment. ED or designee will continue to monitor compliance. See attached new hire checklist

85a - Sanitary Conditions

1. **Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 03/08/2021 at 10:00 AM, there was no paper towel or other means of hand drying in the common restroom on the 3rd floor, which the home uses as a staff PPE change room. The toilet was not flushed and the seat was smeared with feces.

85a - Sanitary Conditions *(continued)*

Plan of Correction **Do Not Accept**

Housekeeping Director corrected at the time of inspection 3/8/21. I respectfully request this violation be withdrawn. This restroom has been utilized as a PPE Donning and Doffing room since 4/2020. The doorway to the room is clearly labeled employees only/Donning-Doffing/Do Not Enter. This room is cleaned between 10-11am daily by housekeeping staff, they had not yet arrived. At the time of inspection no residents were on isolation so no staff would have been using that room that morning. The paper towels that would have been in the dispenser were all in the toilet and trashcan most likely from a resident that entered the area, even though a do not enter sign was on the door. Housekeeping staff would have cleaned the room between 10-11am and the representative entered at 10 am. This room has been returned to a public restroom accessible to staff and residents and on a routine cleaning schedule

Completion Date: *03/08/2021*

Update - 03/29/2021

Please include detailed plan to address the immediate and ongoing measures to prevent this violation from recurring.

Violation Stands: Donning/Doffing requires handwashing/ hand drying as part of the procedure.

Plan of Correction **Accept**

Housekeeping Director corrected at time of Inspection on 3/8/21. Housekeeping Director will audit weekly x4 for cleanliness of bathroom, and then monthly until 100% complaint. ED/Designee will review audits results at the Quarterly QA meetings.

Completion Date: *05/15/2021*

Document Submission **Implemented**

Corrected at time of inspection. Housekeeping Director conducted audits of all bathrooms and general areas weekly x 4 weeks and community has stayed in 100% compliance. Please see attached audit. ED or designee will continue to monitor for compliance

103e - Left Overs

1. **Requirements**

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an unlabeled, undated bowl of French fries in the refrigerator in the SDCU refrigerator.

Plan of Correction **Accept**

ED corrected immediately at the time of inspection 3/8/2021. All team members will be re-educated by the ED/Designee by 4-10-2021 that all food is required to be labeled and dated. Refrigerator log will be updated to confirm all food items are labeled and dated. Weekly audits x 4 or until 100% compliant to be completed by dining department. Audits will be included at the quarterly QA meeting by the ED/Designee.

Completion Date: *04/10/2021*

103e - Left Overs *(continued)*

Document Submission **Implemented**

All team members have been re educated, completed prior to 4 10 2021. Please see attached record of training. Weekly audits were conducted x 4 weeks by Dining Director and have maintained 100% compliance. Audits will be utilized at quarterly QA meeting. ED and/or designee will continue to monitor for compliance.

141b1 Annual Medical Evaluation

1. **Requirements**

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

Description of Violation

Resident #1's most recent medical evaluation was completed on 06/15/2020. The resident's previous medical evaluation was completed on 02/28/2019.

Plan of Correction **Accept**

On 3 10 2021 Director of Resident Care and ED completed an audit of all DME's. ED re educated Director of Resident Care, LPN staff, and Memory Care Director on 3 30 2021. The ED/Designee will complete monthly audits x 4months until 100% compliant to ensure that annual DMEs are completed per regulation. Audit results will be reviewed by Director of Resident Care/designee at quarterly QI meeting.

Completion Date *03/30/2021*

Document Submission **Implemented**

On 3-10-2021 Director of Resident Care and ED completed an audit of all DME's. ED re-educated Director of Resident Care, LPN staff, and Memory Care Director on 3-30-2021. The ED/Designee completed monthly audit for 3/2021 and 4/2021. Audit results will be reviewed by Director of Resident Care/designee at quarterly QI meeting.

187b - Date/Time of Medication Admin.

1. **Requirements**

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Alprazolam 0.25 mg twice daily as needed. Resident #2 s March medication administration record (MAR) does not include the initials of the staff person who administered it on 03/04/2021 at 08:00 PM.

Plan of Correction **Do Not Accept**

All medication administration team members will be trained by the Director of Resident Care/ED on medication administration documentation per regulation by 4-10-2021. Audit to ensure compliance will be reviewed by the Director of Resident Care/Designee at quarterly QI meeting.

Completion Date: *04/10/2021*

Update - 03/29/2021

How often will audits be completed?

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction **Accept**

All Nurses and Med Techs will be re-trained on proper documentation of Medication Administration by Director of Resident Care/Designee by 4/10/21. The DRC/Designee will complete weekly audits x4 weeks, and then monthly until 100% compliant. ED/Designee will review audit results at the Quarterly QA meeting.

Completion Date: *04/10/2021*

Document Submission **Implemented**

All Nurses and Med Techs have been re-trained on proper documentation of Medication Administration by Director of Resident Care/Designee . The DRC/Designee has completed weekly audits x4 weeks, and will continue to audit monthly. ED/Designee will review audit results at the Quarterly QA meeting. Please see attached documentation

187d - Follow Prescriber's Orders

1. **Requirements**

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

Description of Violation

Resident #3 is prescribed Enalapril Maleate 20 mg twice a day at 09:00 AM and 09:00 PM, with an instruction of 'hold if systolic blood pressure is less than 120'. However, the home has administered the medication without taking the resident's blood pressure.

Plan of Correction **Accept**

MAR was re-written to allow for blood pressure to be documented underneath the initial of the medication administrator. This was revised the day of inspection. The MD was made aware of the findings on 3-9-2021. All LPN/med staff will be re-educated by ED/DRC to ensure documentation is included on MAR for any medications with parameters by 4-10-2021. Audit to ensure compliance will be completed by DRC/Designee weekly x 4 weeks until 100% compliant. Results of audits will be reviewed by DRC/Designee at the quarterly QI meetings.

Completion Date: *04/10/2021*

Document Submission **Implemented**

MAR was re-written to allow for blood pressure to be documented underneath the initial of the medication administrator. This was revised the day of inspection. The MD was made aware of the findings on 3-9-2021. All LPN/med staff will be re-educated by ED/DRC to ensure documentation is included on MAR for any medications with parameters by 4-10-2021. DRC/Des gnee conducted audits of all MARs weekly x 4 weeks and 100% compliance achieved. DRC and/or designee will continue to monitor for ongoing compliance. Results of audits will be reviewed by DRC/Designee at the quarterly QI meetings. Please see attached documentation

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The Resident Assessment-Support Plan (RASP) for resident #4, dated [redacted] was not signed by the assessor.

227g -Support Plan Signatures *(continued)*

Plan of Correction **Accept**

Missing Signature was obtained on day of inspection. Audit of all support plans will be completed 4-10-21 by DRC/Designee. LPN and all direct care staff will be re-educated by DRC/ED on RASP regulations by 4 -10-2021. DRC to monitor for continued compliance. The ED/Designee will complete monthly audits x 4 weeks until 100% compliant. Audit results will be reviewed by the DRC/Designee at the quarterly QI meeting.

Completion Date: *04/10/2021*

Document Submission **Implemented**

Missing Signature was obtained on day of inspection. Audit of all support plans was completed by DRC/Designee, please see attached documentation . LPN and all direct care staff have been re-educated by DRC/ED on RASP regulations. DRC to monitor for continued compliance. The ED/Designee completed audits in March and April and will continue to monitor for compliance. Audit results will be reviewed by the DRC/Designee at the quarterly QI meeting. Please see attached documentation.

231c - Preadmission Screening

1. **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 #5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's written cognitive preadmission screening was completed on [redacted]. Resident #6 was admitted to the SDCU on [redacted] However, the resident's written cognitive preadmission screening was completed on [redacted]

Plan of Correction **Accept**

Director of Resident Care and Memory Care Director were re-educated to memory care prescreen regulation by ED on 3-10-21. All new move in charts will be reviewed by the ED/Designee to monitor ongoing compliance with pre-screens. Audit to ensure compliance will be completed by the DRC x 4 weeks until 100% compliant. Audit results will be reviewed by the DRC/Designee at the quarterly QI meeting

Completion Date: *04/02/2021*

Document Submission **Implemented**

Director of Resident Care and Memory Care Director were re-educated to memory care prescreen regulation by ED on 3-10-21. All new move in charts have been and will continue to be be reviewed by the ED/Designee to monitor ongoing compliance with pre-screens. Audit to ensure compliance was completed by the DRC x 4 weeks with 100% compliance. Audit results will be reviewed by the DRC/Designee at the quarterly QI meeting.

251b - Record Entries Legible

1. **Requirements**

2600.

251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

251b - Record Entries Legible *(continued)*

Description of Violation

On the controlled substance sign-out sheet for resident #1's Alprazolam 0.25 mg, the 2nd entry is crossed out without proper notation. The 3rd entry has the amount remaining written over. On the 2nd entry for 02/06/2021, time is written over. On the entry for 03/03/2021, amount remaining is written over. On the entry for 03/05/2021, both time and amount used are written over.

On the controlled substance sign-out sheet for resident #6's Lorazepam 0.5 mg, the 3rd entry date and the 8th entry time are written over. The 9th entry is crossed out without proper notation.

Plan of Correction **Accept**

All medication administration staff will be re-educated by 4-10-21 by the DRC/Designee on medication documentation on MAR and controlled substance count logs to include legible documentation and appropriate correction of errors. Audit to ensure compliance will be completed by DRC weekly x 4 weeks until 100 % compliant. Results will be reviewed by DRC/Designee at the quarterly QI meeting.

Completion Date: *04/10/2021*

Document Submission **Implemented**

All medication administration staff have been re-educated by the DRC/Designee on medication documentation on MAR and controlled substance count ogs to include legible documentation and appropriate correction of errors. Audit to ensure compliance have been completed by DRC weekly x 4 weeks . Results will be reviewed by DRC/Designee at the quarterly QI meeting. Please see attached documentation