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

August 10, 2023

[redacted], ED
SIMPSON MEADOWS
101 PLAZA DRIVE
DOWNINGTOWN, PA, 19335

RE: SIMPSON MEADOWS
101 PLAZA DRIVE
DOWNINGTOWN, PA, 19335
LICENSE/COC#: 14118

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/22/2023 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: *SIMPSON MEADOWS* **License #**: *14118* **License Expiration**: *03/01/2024*

Address: *101 PLAZA DRIVE, DOWNINGTOWN, PA 19335*

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

Administrator

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

Legal Entity

Name: *SIMPSON MEADOWS*

Address: *101 PLAZA DRIVE, DOWNINGTOWN, PA, 19335*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/17/1999* **Issued By**: *East Caln Twp*

Staffing Hours

Resident Support Staff: *99* **Total Daily Staff**: *171* **Waking Staff**: *128*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *05/22/2023*

Inspection Dates and Department Representative

05/22/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *43*

Special Care Unit

In Home: *Yes* **Area**: *McKendree Gardens* **Capacity**: *81* **Residents Served**: *29*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *43*

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

Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

05/22/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2023*

06/15/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *06/13/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2023*

Inspections / Reviews *(continued)*

06/27/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *06/20/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *06/30/2023*

08/10/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/30/2023*

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

25b Contract signatures and renewal

1. Requirements

2800.
25b . The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees. The contract must run month-to-month with automatic renewal unless terminated by the resident with 14 days notice or by the residence with 30 days notice in accordance with § 2800.228 (relating to transfer and discharge).

Description of Violation

Resident # 1, admitted to the home on [redacted], did not sign [redacted] contract.

Plan of Correction ***Directed [redacted] - 06/22/2023)***

*The Resident- Residence Agreement will be reviewed with and provided to Resident #1 and POA by the Administrator by **6/30/23**. Each current resident's file will be reviewed to ensure the completed and signed agreement is in their record by the Administrator, by **7/15/23**. The Sales counselor will be responsible for reviewing the Resident- Residence Agreement with each new resident and his/her responsible party (if applicable) prior to or within 24 hours of admission. The Administrator will monitor for compliance and track completion on a tracking log, **starting immediately.** The Administrator will report compliance at the Quality Assurance Performance Meeting, **at least quarterly, starting immediately**.. **Documentation will be maintained for the Departments Review (Directed by [redacted] 6/22/23)***

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 07/10/2023)

41e Signed statement

2. Requirements

2800.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident # 2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

Resident #2 will be given and educated on resident rights and complaint procedures by the Administrator. The Administrator will monitor for compliance and track completion on a tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***Resident #2 will be given and educated on resident rights and complaint procedures by the Administrator, by 6/30/23.***
2. ***The Business manager will conduct an audit of all resident records to ensure all residents have been advised of their rights by 7/15/23.***
3. ***The Administrator will monitor for compliance and track completion on a tracking log, by 7/15/23.***
4. ***The Administrator will report compliance at the Quality Assurance Performance Meeting, at least quarterly, starting immediately. Documentation will be maintained for the Departments review (DPOC by [redacted] 6/22/23}.***

41e Signed statement *(continued)*

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 08/10/2023)

85a Sanitary conditions

3. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 5/22/23, at 3:15PM, rooms 127 and 242 in McKendree Gardens smelled strongly of urine, particularly in the bathrooms. The bathroom in room 242 had a used pad soaked in urine. In room 135, at 3:20PM, a basket of clothing was in the shower stall.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

The pad soaked in urine in room 242 and basket of clothing in shower stall room 127 were immediately removed when noted during the survey. All team members will be educated on keeping sanitary conditions and shower stalls empty. The Wellness Director or designee will conduct rounds to ensure the areas are free of hazards. Rounds will be completed five times weekly for 30 days, weekly for 30 days, and monthly for three months.

1. ***The pad soaked in urine in room 242 and basket of clothing in shower stall room 127 were immediately removed when noted during the survey.***
2. ***All team members will be educated on keeping sanitary conditions and shower stalls empty, by 7/10/23 by the Housekeeping or maintenance manager.***
3. ***The Wellness Director or designee will conduct rounds to ensure the areas are free of hazards, starting immediately.***
4. ***Rounds will be completed five times weekly for 30 days, weekly for 30 days, and monthly for three months. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *11/16/2023*

Implemented [redacted] - 08/10/2023)

85d Trash cans – kitchen/bath

4. Requirements

2800.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 5/22/23, at 9:50AM, there was an uncovered trash can in the cafe.

Plan of Correction ***Accept [redacted] - 06/15/2023)***

Lid was immediately placed back on the trash can by Dining Services Manager. An in service was held on 6/9/23 on sanitation standards. New trash cans with attached lids were purchased on 6/1/23. Dining services managers will complete weekly safety walks in the company safety app and note if they find can lids not in compliance.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented ([redacted] - 07/10/2023)

100a Exterior – free of hazards

5. Requirements

2800.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

The walking path in the SCDU courtyard had two cracks, each raised at least one-half inch above the ground, presenting tripping hazards.

Plan of Correction ***Directed (- 06/22/2023)***

The area of the walking path has been blocked off from resident access while we work with a third-party contractor to prepare and finalize repairs. The Executive Director or designee will inspect the courtyard twice a week for one month, then weekly x 2 months to ensure no tripping hazards are present. The Executive Director will report compliance at the Quality Assurance Performance Meeting.

1. ***The area of the walking path has been blocked off from resident access while we work with a third-party contractor to prepare and finalize repairs by the mainenance manager, by 6/22/23.***
2. ***The mainenance manager will obtain a contract to repair the walking path by 6/30/23 and complete the repair by 7/30/23.***
3. ***The Executive Director or designee will inspect the courtyard twice a week for one month, then weekly x 2 months to ensure no tripping hazards are present, starting immediately.***
4. ***The Executive Director will report compliance at the Quality Assurance Performance Meeting, at least quarterly, starting immediately.***
5. ***Documentation will be maintained for the Department review. DPOC by 6/22/23.***

Directed Completion Date: *09/08/2023*

Implemented (- 08/10/2023)

103e Leftovers

6. Requirements

2800.
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 were unlabeled, undated trays of potato chips, chicken, and french fries in the cafe freezer. The SCDU common fridge contained two plates and a container of unlabeled, undated food.

Plan of Correction ***Accept (- 06/15/2023)***

Plates were immediately disposed of. Staff in-service took place on 6/9/23 covering properly dating and labeling guidelines with no plated food being saved. The Dining service manager or designee will complete an audit twice a week for three months. The Dining service manager will report compliance at the Quality Assurance Performance Meeting.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented - 07/10/2023)

103g Storing food

7. Requirements

2800.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A muffin tray in the Main Kitchen freezer was open and unsealed, as its plastic wrap covering had ripped.

Plan of Correction ***Accept ([redacted] - 06/15/2023)***

Muffin tray disposed of immediately. Staff was in-serviced on 6/9/23 on proper food storage guidelines. The Dining service manager or designee will complete daily rounds with an audit twice a week for three months. The Dining service manager will report compliance at the Quality Assurance Performance Meeting.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented ([redacted] - 07/10/2023)

103i Outdated food

8. Requirements

2800.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 5/22/23, the Main Kitchen refrigerator had a container of butter marked with an expiration date of 5/21/23. A container of raw turkey patties was marked with an expiration date of 5/14/23.

Plan of Correction ***Accept ([redacted] - 06/15/2023)***

The two items were immediately disposed of. Staff in service took place 6/9/23 on proper storage. The Dining service manager or designee will complete an audit twice a week for three months. The Dining service manager will report compliance at the Quality Assurance Performance Meeting.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] - 07/10/2023)

132g Fire drills – days/times

9. Requirements

2800.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The residence routinely holds fire drills on the last day of each month as evidenced by the following drills 1/31/23, 3/31/23, 2/28/23, 4/28/23. Fire drills in the last quarter of 2022 were held during the last week of each month: 12/22/22, 11/30/22, 10/31/22.

Plan of Correction ***Directed [redacted] - 06/22/2023)***

The Facilities Director was educated on the importance of conducting a fire drill on various times within a month by the Executive Director. A new calendar will be created to plan a different week within every month to have the monthly Fire Drill. Dates will be random within the specified week and will include a nighttime fire drill scheduled every 6 months. Facilities Director will ensure fire drills are completed monthly and Executive Director will report compliance at the Quality Assurance Performance Meeting.

1. ***The Facilities Director was educated on the importance of conducting a fire drill on various times***

132g Fire drills – days/times (continued)

within a month by the Executive Director by 6/22/23.

2. ***The Facilities Director will maintain a private calendar to plan monthly fire drills are held on different weeks and days of the month (that maintains confidentialy to ensure the drills are unannounced), starting immediately. Dates will be random within the specified week and will include a nighttime fire drill scheduled every 6 months.***
3. ***Facilities Director will ensure fire drills are completed monthly, on different days and weeks of the month, starting immediately.***
4. ***Executive Director will review the Fire Drill records at least quarterly and report compliance at the Quality Assurance Performance Meeting, starting immediately.***
5. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *05/26/2024*

Implemented [redacted] - 08/10/2023)

141b1 Annual medical evaluation

10. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #3's most recent medical evaluation did not include the date the evaluation was completed.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

Resident #3's medical evaluation will be completed to reflect the correct date by the Wellness Director. Current ADME's will be reviewed by the Wellness Director for accuracy and completeness. ADME's will be reviewed for accuracy by the Wellness Director prior to filing in resident's chart. The Administrator will monitor for compliance and track completion on a tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***Resident #3's medical evaluation will be completed to reflect the correct date by the Wellness Director. Current ADME's will be reviewed by the Wellness Director for accuracy and completeness, by 6/30/23.***
2. ***ADME's will be reviewed for accuracy by the Wellness Director prior to filing in resident's chart, starting immediately upon the completion of the ADME.***
3. ***The Wellness Director will conduct an audit of all resident ADME's to ensure they have been completed annually, by 7/30/23 and correct/update any ADME.***
4. ***The Administrator will monitor for compliance and track completion on a tracking log at least quelyarterly, starting immediatly.***
5. ***The Administrator will report compliance at the Quality Assurance Performance Meeting at least quarterly, starting immediatly.***
6. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 08/10/2023)

185a Storage procedures

11. Requirements

2800.
185.a. The residence 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 [redacted] the glucometer designated for resident #4, was set to an incorrect date of January 12.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

Resident #4 glucometer was calibrated with correct date and time when found. All resident glucometers were audited to ensure the calibration is accurate. An audit will be completed by the Wellness Director or designee five times weekly for 30 days, weekly for 30 days, and monthly for three months.

1. ***Resident #4 glucometer was calibrated with correct date and time when found.***
2. ***All clinical staff and med techs will be trained on the correct method of calibrating resident glucometers by 6/30/23.***
3. ***All resident glucometers were audited to ensure the calibration is accurate, by 6/22/23.***
4. ***An audit will be completed by the Wellness Director or designee five times weekly for 30 days, weekly for 30 days, and monthly for three months, starting immediately.***
5. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *11/16/2023*

Implemented [redacted] 08/10/2023)

191 Resident right to refuse

12. Requirements

2800.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #2, admitted [redacted], and resident #5, admitted [redacted], have not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction ***Directed [redacted] - 06/22/2023)***

The Resident-Residence Agreement, which includes education on the resident's right to question or refuse a medication if the resident believes there may be a medication error, will be reviewed with and provided to Resident #2 and Resident #5 by the Administrator. The Sales Counselor will be responsible for reviewing the Resident-Residence Agreement with each new resident and responsible party (if applicable) prior to or within 24 hours of admission. The Administrator will monitor for compliance and track completion on a tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***The Resident-Residence Agreement, which includes education on the resident's right to question or refuse a medication if the resident believes there may be a medication error, will be reviewed with and provided to Resident #2 and Resident #5 by the Administrator,by 6/30/23.***
2. ***The Sales Counselor will be responsible for reviewing the Resident- Residence Agreement with each new resident and responsible party (if applicable) prior to or within 24 hours of admission, starting immediately.***

191 Resident right to refuse (continued)

3. ***The Sales Counselor will audit all resident agreements to ensure all residents have been educated on the right to refuse and update any agreemment by 7/15/23.***
4. ***The Administrator will monitor for compliance and track completion on a tracking log, at least quarterly, starting immediately.***
5. ***The Administrator will report compliance at the Quality Assurance Performance Meeting, at least quarterly, starting immediately.***
6. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *07/31/2023*

Implemented ([redacted] - 08/10/2023)

225a1 Assessment – annually

13. Requirements

2800.
225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident # 3's most recent assessment and support plan is dated [redacted]. Resident # 5's most recent assessment and support plan is undated, making it unclear if it was completed timely.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

Resident #3 and Resident #5 assessment and support plan's will be updated to reflect a current accurate date by the Wellness Director. Resident assessments will be completed in a timely manner by the Wellness Director. The Administrator will track compliance on a tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***Resident #3 and Resident #5 assessment and support plan's will be updated to reflect a current accurate date by the Wellness Director, by 6/30/23.***
2. ***The Admiistrator and/or the Wellness Director will develop a tickler document to ensure all assessments and support plans are updated timely as required by this regulation, by 7/10/23.***
3. ***The Wellness Director and/or lead clinical staff will conduct an audit of all resident assessments and support plans to ensure they have been updated timely, starting immediately.***
4. ***Resident assessments will be completed in a timely manner by the Wellness Director, starting immediately.***
5. ***The Administrator will track compliance on a tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting, at least quartely, starting immediately.***
6. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 08/10/2023)

227g Support plan - signatures

14. Requirements

227g Support plan - signatures *(continued)*

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident # 5 participated in the development of his/her support plan for 2023. However, the resident wrote an incorrect signature date of [redacted].

Plan of Correction ***Directed [redacted] - 06/22/2023)***

Resident #5 support will be updated and documented to reflect an accurate date by the Wellness Director. Resident support plans will be monitored for signatures of all needed parties by the Wellness Director. The Administrator will track compliance on the tracking log. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***Resident #5 support will be updated and documented to reflect an accurate date by the Wellness Director, by 6/30/23.***
2. ***All Resident support plans will be monitored for signatures of all needed parties by the Wellness Director, starting immediately.***
3. ***The Administrator or Wellness Director will develop a tracking form to ensure all support plans are updated, signed and correctly reflect the resident needs, then audit all resident support plans by 7/15/23.***
4. ***The Administrator will track compliance on the tracking log and will report compliance at the Quality Assurance Performance Meeting, at least quarterly, starting immediately.***
5. ***Documentation will be maintained for the Departments review. DPOC by [redacted] 6 /22/23.***

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 08/10/2023)

227h Support plan – refusal sign

15. Requirements

2800.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1 participated in the development of his/her support plan on [redacted]. The resident did not sign the support plan. The residence did not make a notation regarding the resident's refusal to sign. Resident #6 participated in the development of his/her support plan on [redacted]. The resident did not sign the support plan. The residence did not make a notation regarding the resident's refusal to sign.

Plan of Correction ***Directed ([redacted] - 06/22/2023)***

Resident #1 and Resident #6 support plans will be signed or documented of a refusal to sign by the Wellness Director. The Wellness Director will be educated on the importance of documenting a resident's refusal to sign a support plan by the Administrator. The Wellness Director will monitor support plans to ensure residents sign the plan or their refusal is documented.

1. ***Resident #1 and Resident #6 support plans will be signed or documented of a refusal to sign by the Wellness Director.***
2. ***The Wellness Director will be educated on the importance of documenting a resident's refusal to***

227h Support plan – refusal sign (continued)

sign a support plan by the Administrator, by 6/30/23.

3. ***The Wellness Director will monitor support plans to ensure residents sign the plan or their refusal is documented, starting immediately and offer the residents the ability to sign the support plan at least twice, documenting the approach.***
4. ***The Administrator or Wellness Director will develop a tracking form to ensure all support plans are updated, signed and correctly reflect the resident needs, then audit all resident support plans by 7/15/23.***
5. ***Documentation will be available for the Departments review. DPOC by [redacted] 6/22/23.***

Directed Completion Date: *07/31/2023*

Implemented [redacted] - 08/10/2023)

231c1 Preadmit screening

16. Requirements

2800.
231.c.1.i. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's cognitive preadmission screening form shall be completed for each resident within 72 hours prior to admission to a special care unit.

Description of Violation

Resident #3 was admitted to the special care unit on [redacted]. However, resident #3's written cognitive preadmission screening was not completed. Resident #6 was admitted to the special care unit on [redacted]. However, resident #6's written cognitive preadmission screening was not completed.

Plan of Correction ***Directed [redacted] - 06/22/2023)***

The written cognitive preadmission screening will be completed for Residents #3 however Resident #6 is not a special care unit occupant. All other active resident records in the SCDU will be audited for completion of the screening form by the Wellness Director. The Administrator will utilize a tracking system to ensure written cognitive screening forms are completed for each resident within 72 hours (about 3 days) prior to admission to the SCDU. The Administrator will report compliance at the Quality Assurance Performance Meeting.

1. ***The written cognitive preadmission screening will be completed for Residents #3 by 6/30/23 (however Resident #6 is not a special care unit occupant.)***
2. ***All other active resident records in the SCDU will be audited for completion of the screening form by the Wellness Director, by 7/10/23.***
3. ***The Administrator will utilize a tracking system to ensure written cognitive screening forms are completed for each resident within 72 hours (about 3 days) prior to admission to the SCDU, starting immediately.***
4. ***The Administrator will report compliance at the Quality Assurance Performance Meeting, at least quarterly, starting immediately.***
5. ***Documentation will be maintained for the Departments review. DPOC 6/22/23.***

Directed Completion Date: *07/31/2023*

231c1 Preadmit screening *(continued)*

Implemented [redacted] - 08/10/2023)

233c Key-locking devices

18. Requirements

2800.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

There were three exits which did not include conspicuously posted directions for operating the residence's locking mechanism: the exit from the main entrance to the special care unit, from the activity room to the courtyard, and from the courtyard to the home's exterior.

Plan of Correction ***Accept ([redacted] - 06/15/2023)***

All locking keypads were labeled with instructions for exit by the facility maintenance supervisor on 6/1/23. Placement of instruction labels will be audited by the Executive Director or designee five times weekly for 30 days, weekly for 30 days, and monthly for three months.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] - 07/10/2023)