



March 17, 2014

Kelly Williams, Director
Ridge Avenue Eldercare Services
2653 West Glenwood Avenue
Philadelphia, PA 19121

RE: Ridge Avenue Eldercare Services
License # 314290 - Regular

Dear Ms. Williams:

As a result of the Department of Aging's licensing inspection of the above named facility on 01/15/2014, seven areas of non-compliance were identified. The legal entity submitted an acceptable written plan to correct each area of non-compliance. Therefore, the Department issued a Regular License, indicating compliance with applicable statutes, ordinances and regulations.

Thank you for your continued effort to provide quality older adult daily living services. If you have questions, please contact me at (717) 214-6716.

Sincerely,

A handwritten signature in black ink, appearing to read 'Kevin Longenecker', written in a cursive style.

Kevin Longenecker
Director

Enclosures

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF AGING

LICENSE

This license is hereby granted to ELDERLY AND DISABLED SERVICES, LLC

LEGAL ENTITY

To operate RIDGE AVENUE ELDERCARE SERVICES

(NAME OF CENTER)

Located at 2653 WEST GLENWOOD AVENUE PHILADELPHIA, PA 19121

(COMPLETE ADDRESS OF CENTER)

To provide older adult daily living services.

The total number of persons which may be served at one time may not exceed. 52

(MAXIMUM CAPACITY)

Restrictions: _____

This license is granted in accordance with the Act of July 11, 1990 (P.L. 499, No. 118) and Regulations.

TITLE 6. PA CODE. CHAP. 11. OLDER ADULT DAILY LIVING CENTER

(NUMBER AND TITLE OF REGULATIONS)

Dated July 03, 1993

and shall remain in effect from April 01, 2014

until March 31, 2015

unless sooner revoked for non-compliance with applicable laws and regulations.

No: 314290 - Regular



ISSUING OFFICER

NOTE: This license is issued for the above address only and is not transferable. This license should be posted in a conspicuous place in the center.

Issued On: March 17, 2014

AGL01

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER LICENSE NUMBER: 314290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/2014
NAME OF PROVIDER OR SUPPLIER Ridge Avenue Eldercare Services		STREET ADDRESS, CITY, STATE, ZIP CODE 2653 WEST GLENWOOD AVENUE PHILADELPHIA, PA 19121		
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1 000	Initial Comments A State licensure visit was completed on 1/15/2014 and it was determined that Ridge Avenue Eldercare Services was not in compliance with the following requirements of 6 PA Code, Chapter 11, Older Adult Daily Living Centers regulations:	1 000		
1 630	11.33(f) Program staff orientation and training The Department may require that centers make reasonable modifications, regarding curricula or the selection and use of trainers, in order to satisfy the requirements of this section. This STANDARD is not met as evidenced by: Findings: Based on a review of staff training records it was determined that staff #1 had not taken the mandatory director's training course. Center directors were initially informed of this new training course on 01/28/2013, and several times subsequently, that this training must be completed by June, 30, 2013.	1 630	Plan of Correction is required 11.33(f) The Center Administrator has taken and received the certificate or the mandated training by 4/29/2013. The center has a newly hired staff person from another department to take the mandatory director's training course in the absence of the Center Administrator. The supervisor under the Center Administrator has taken the course and received certification as of 1/24/2014. Center Administrator certificate ID# : P30.1367250623.4222 Supervisor certificate ID # : P30.1390625535.15495 (Please See Attached Documentation for Citation # 1) <i>KW 1/28/14</i>	
11590	11.102(a) Client physical examination and med report To be admitted, an applicant whose needs, as	11590	11.102 (a) Center Administrator and Nursing Staff will ensure that a physical examination is completed three	

AUTHORIZED PROVIDER REPRESENTATIVE'S SIGNATURE

Kelly Williams

TITLE *Administrator*

(X6) DATE *1/28/14*

DEPARTMENT OF AGING APPROVAL

[Signature]

Chief Division of Licensing

DATE *3/3/14*

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11590	Continued From page 1 determined through intake screening, may appropriately be met in a center, shall also have had a physical examination within 3 months prior to admission and annually thereafter. This STANDARD is not met as evidenced by: REPEAT Findings: Based on a review of six of thirty eight client records, it is determined that the center failed to ensure that an annual physical examination was completed for one client. A review of medical records for Client #5 revealed that the last physical examination was completed on 4/02/2012 and the most current physical was completed on 5/30/2013 which is one month and twenty-eight days past the annual date.	11590	months prior to admission and annually there after. Nursing staff and Center Administrator will audit potential client chart for proper admission requirements including history and physical, PPD results and/ or chest x-ray, intake information, application, and medical release. The center has created a letter to inform client, client's family and physician of the date of last physical, the date the form is due and the number of days remaining, also added to the letter, client will not be able to attend center unless physical is completed within the annual time frame. This was implemented as of 1/24/2014. The center will continue to utilize the use of the spreadsheet created with consumer's Name, DOB, Start Date, Physical Date, Care Plan, Fire Safety Notes, and next care plan review. The nursing staff was unsuccessful in retrieving Client # 5 history and physical in a timely manner prior to the annual due date. The Doctor and Client were given notice 30 days prior to due date. Client was informed that she could not return to center until this information was received. During each care plan review charts will be audited by	
11610	11.102(c) Client physical examination and med report The medical report shall include: (1) A review of previous health history, current medication regimen, use of medical treatments and therapies; current health problems and conditions; and a schedule for client self-administration of medications. (2) The record of a general physical examination. (3) General sensory functioning; sensory aids. (4) An indication that a tuberculin skin test has been	11610		

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11610	Continued From page 2 administered with negative results within 2 years; or, if tuberculin skin test is positive, the results of a chest X-ray. (5) To the extent that confidentiality laws permit, written authorization in the form of a signed statement that the client is free of communicable disease, or that the client has a communicable disease but is able to be in the center if specific precautions are taken which will prevent the spread of the disease to other individuals. (6) Medical information pertinent to diagnosis and treatment in case of an emergency. This STANDARD is not met as evidenced by: Findings: Based on a review of six of thirty eight client medical records, it was found that the center failed to obtain a written authorization in the form of a signed statement that a client is free of communicable disease. A review of medical records for Client #1 revealed that the communicable disease statement, on the physical examination dated 9/11/2013 was missing.	11610	Center Administrator and Nursing Staff for compliance. (Please See Attached Documentation for Citation # 2) <i>KOR 1/29/14</i> 11.102 (c) The Center's Registered Nurse will ensure that there is written authorization in the form of a signed statement that a client is free from communicable disease when using the doctor's forms. Physician for client # 1 was contacted 1/15/2014 in reference to communicable disease's letter received back 1/23/2014 stating that client # 1 upon her last examination was found to have no communicable disease. The center has created a form as of 1/24/2014 in reference to communicable disease. Also, upon receipt of physical exam forms the registered nurse will be responsible for reviewing the physical form to ensure accuracy and will sign a progress note that physical was received and reviewed. (Please See Attached Documentation for Citation # 3) <i>KOR 1/28/14</i>	
11670	11.104(c) Development of individual care plan The individual care plan shall contain at least the following elements: (1) An identification of needs, which can be addressed at the center, and the order in which they will be addressed.	11670	11.104 (c) The Center Administrator and Staff will ensure that the pre-determined date for the next care plan will be written on every client's care plan. The date of next review for client # 4 was added to care plan on 1/15/2014	

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11670	Continued From page 3 (2) The goals to be achieved. (3) The methods and activities for reaching these goals within a specified time frame. (4) Documentation of the client's progress toward meeting each goal and of goal attainment when, as required in §11.105 (relating to review and revision of individual care plan), the plan is reviewed and, as necessary, revised. (5) Predetermined date for the next review. (6) An identification of staff persons responsible for the implementation of the plan. This STANDARD is not met as evidenced by: Findings: Based on a review of six of thirty-eight client records, it was determined that the predetermined date for the next review was missing. The care plan for Client #4, dated 8/14/2013 did not have the required predetermined date of the next review.	11670	client # 4 next care plan date is 2/14/14. We will revise the last page of the care plan to add an additional signature line for RN to ensure the date of next review is written. An audit tool has been created to ensure accuracy. (Please See Attached Documentation for Citation #4) <i>DN 1/20/14</i>	
11760	11.109 Service documentation Progress notes on each client shall be written at least monthly and shall also be written as needed to reflect a review of the care plan and goals and objectives in light of changes in the client's status. Treatment notes and notes on significant events, when appropriate, shall be recorded according to professional standards. This STANDARD is not met as evidenced by:	11760	11.109 The Center Administrator and or Nursing Staff will ensure that a written progress note is completed the first week of a new client's arrival. Client #1 started the program on 11/16/2013 and her first progress note was written on 12/1/2013. Client # 2 started the program on 11/12/2013 and her progress note was written on	

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11920	<p>11.132(c) Staff physical examination</p> <p>Findings: Based on a review of six of thirty-eight client records it was determined that the center failed to ensure that written progress notes were completed at least monthly for three clients. A review of client records revealed that Client #1 was admitted on 11/06/2013 but the initial progress note entry was not created until 12/01/2013, client # 2 was admitted on 11/12/2013 but the initial progress note was not created until 12/12/2013 and Client #3 was admitted on 9/30/2013 but the initial progress note was not created until 10/25/2013.</p> <p>The medical report shall include: (1) The record of a physical examination. (2) Indication that a tuberculin skin test has been administered to the individual with negative results within 2 years; or if tuberculin skin test is positive, the results of a chest X-ray. (3) To the extent that confidentiality laws permit, written authorization in the form of a signed statement that the individual is free of communicable diseases or that the individual has a communicable disease but is able to work in the center if specific precautions are taken that will prevent the spread of the disease to clients. (4) Information on a medical problem, which might interfere with the health of the clients.</p> <p>This STANDARD is not met as evidenced by:</p>	11920	<p>12/12/2013. Client # 3 started the program on 9/30/2013 and her progress note was written on 10/25/2013.</p> <p>An admission assessment/note form has been created to ensure baseline information and progress note is done upon admission.</p> <p>An audit tool has been created to ensure accuracy.</p> <p>(Please See Attached Documentation for Citation # 5)</p> <p><i>KLW 1/28/14</i></p> <p>11.132(c) The Center Administrator, Human Resource Department, and Registered Nurse will ensure that before any staff member is hired that their physical form is filled out in its entirety. Staff member # 2's physician failed to fill out the result of the PPD placed on 11/22/2013.</p> <p>On 11/25/2013, the physician failed to list the results of the test. On 1/15/2014 Staff member # 2 contacted her physician and was faxed the results of her PPD which were negative. The registered nurse will review the physical form for accuracy and write a progress note stating that the physical form has been completed.</p>	

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11920	Continued From page 5 Findings: Based on a review of four of twelve staff records, it was determined that the center failed to ensure that a tuberculin skin test has been administered to one staff person with negative results. A review of the record for Staff #2 revealed that the center placed the tuberculin test on 11/22/2013 and read the tuberculin test on 11/25/2013 but failed to list the results of the test.	11920	(Please See Attached Documentation for Citation # 6) <i>KSW 1/28/14</i>	
12380	11.191(b) Emergency information Emergency information for a client shall include the following: (1) A written agreement with the client or responsible party regarding emergency care and ambulance transportation, when the agreement is not included as an element in the enrollment agreement in §11.103 (relating to enrollment agreement). (2) The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency. (3) The name, address and telephone number of the client's physician or source of health care and hospital preference. (4) The name, address and telephone number of the person able to give consent for emergency medical treatment, if applicable. (5) A copy of the client's most recent annual physical examination, which shall include information on current diagnosis, medications and allergies. This STANDARD is not met as evidenced by:	12380	11.191 (b) The Center Administrator and Nursing Staff have ensured that a copy of the client's recent physical examinations including; information on current diagnosis, medication and allergies was an attached to client face sheet book in the portable emergency file. We will utilize or audit tool to replace physicals that need to be updated on annual basis. (Please See Attached Documentation for Citation #7) <i>KSW 1/28/14</i>	

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	Findings: Based on a review of the center's portable emergency file and a discussion with the center Director, it was determined that the center failed to include copies of the clients' most recent annual physical examinations including information on current diagnosis, medications and allergies.			