

COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE

# CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to SENIOR LIVING NP, LLC

LEGAL ENTITY

To operate PLUSH MILLS

NAME OF FACILITY OR AGENCY

Located at SECOND AND FOURTH FLOORS, 501 PLUSH MILL ROAD, WALLINGFORD, PA. 19086

(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE

To provide Personal Care Homes

TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed 79  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

(MAXIMUM CAPACITY)

Restrictions: \_\_\_\_\_

This certificate is granted in accordance with the Public Welfare Code of 1967, P. L. 31, as amended, and Regulations

55 Pa. Code Chapter 2600: Personal Care Homes

(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from December 9, 2011 until December 9, 2012,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 131040

*Robert E. Robinson*

ISSUING OFFICER

*R. C. King*

DIRECTOR

NOTE: This certificate is issued for the above site(s) only and is not transferable  
and should be posted in a conspicuous place in the facility.

PW 628 - 01/11



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
PO BOX 2675  
HARRISBURG, PENNSYLVANIA 17105-2675

ADULT RESIDENTIAL LICENSING

PHONE: (717) 783-3670  
FAX: (717) 783-5662

DEC 14 2011

Ms. Kelly Cook Andress, President  
Senior Living NP, LLC  
Plush Mills  
Second and Fourth Floors  
501 Plush Mill Road  
Wallingford, Pennsylvania 19086

Dear Ms. Andress:

As a result of the Department of Public Welfare's licensing inspection on July 6, 2011 and July 7, 2011 of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.

All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.

A regular license is being issued based on the enclosed Violation Report. Your license is enclosed.

Sincerely,

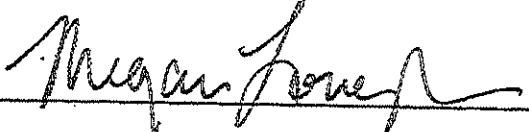

A handwritten signature in black ink, appearing to read 'R. Melusky', with a long horizontal stroke extending to the right.

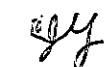
Ronald Melusky  
Director

Enclosures  
License  
Violation Report

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

Page 1 of 15

NAME AND ADDRESS OF PERSONAL CARE HOME PLUSH MILLS, 501 PLUSH MILL ROAD WALLINGFORD, PA 19086		CURRENT LICENSE NUMBER 131040	
INSPECTION DATES (Include all dates of the inspection) 07/06/2011		REGIONAL REPRESENTATIVE Roslyn Brewer, Justin Trupp	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <p style="text-align: center; font-size: 1.2em;"><i>Megan Longley, Executive Director</i></p>			
SIGNATURE OF LEGAL ENTITY 	DATE 8-23-11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION 	DATE 9/14/11

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
28e In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act.	There was no documentation of the refund owed or money owed by resident #8, who's belongings were removed from the home on 5/12/11.	07/12/11	<ol style="list-style-type: none"> <li>1. Immediate Correction: There was no documentation of the refund owed or money owed by resident #8 who's belongings were removed from the home on 05/12/11. The final invoice (see attached F) reflects payment due to the resident was paid via check #5885 dated 06/02/11 had been mailed to the family at the time of the survey but had not yet been filed.</li> <li>2. Community review: No additional review was required.</li> <li>3. Prevention in future: When the move-out statements are created at each billing cycle the Associate Executive Director will print out the final reconciliation and include in resident file.</li> <li>4. Responsible for monitoring and compliance: Associate Executive Director.</li> </ol>	 11/2/11

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME PLUSH MILLS, 501 PLUSH MILL ROAD WALLINGFORD, PA . 19086		CURRENT LICENSE NUMBER 131040	
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PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <p style="text-align: center; font-size: 1.2em; margin: 0;"><i>Megan Lonaker, Executive Director</i></p>			
SIGNATURE OF LEGAL ENTITY 	DATE 9.23.11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION 	DATE 11/2/11

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
54a Direct care staff persons shall have the following qualifications: (1) Be 18 years of age or older, except as permitted in subsection (b). (2) Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry. (3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care	Direct care staff person A, has an online diploma dated 4/13/10.	08/01/11	1. Immediate Correction: Employee was hired on October 22, 2009 with 15 years experience in the health care field. We had verbal commitment from her that she had a Jamaican high school diploma, however, we failed to get the required certified statement from her. She also stated that, at that time she was working on completing an American GED course and receiving assistance from the Delaware County Literacy Council. On April 13, 2010 she provided us a copy of her on-line GED diploma which was in her file and reviewed at the Community by the surveyors. A waiver request was submitted to DPW on 7/11/11 requesting approval of the on-line diploma (see attached A). We have subsequently exchanged information with DPW, including providing additional information to the agency.	 11/23/11

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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services with reasonable skill and safety.	<i>54a (cont.)</i>		<p>2. Community review: By 09/01/11 all active care staff employee files will have been audited to ensure that all Direct Care Staff have a high school diploma, GED or active registry status on the PA nurse aide registry. Any staff found to not meet these requirements will either be suspended until proper credentialing is provided to the Community, or waivers will be requested from DPW as appropriate.</p> <p>3. Prevention in future: The Director of Nursing has inspected all new files for completion and no other staff were identified as not complying with the requirement to provide have a high school diploma, GED or active registry status on the PA nurse aide registry. Additionally, all new direct care staff will provide the appropriate documentation at the time of hire.</p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

301  
Page 1 of 15

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SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>	DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>LR</i>	DATE <i>11/2/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
	<i>54a (cont.)</i>		<p>4. Responsible for monitoring and compliance: The Director of Nursing and HR Director or their designees will be responsible for monitoring future compliance. In addition the Executive Director conducts a monthly audit to ensure accurate completion of all new hire files</p> <p><i>Direct care staff person A will work in an ancillary capacity only until appropriate documentation of qualifications can be obtained or until a waiver can be granted.</i></p> <p style="text-align: right;"><i>LR</i> <i>11/2/11</i></p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>		DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>JL</i>
		DATE <i>10/4/11</i>	

REGULATION 55 Pa. Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
<p>65g</p> <p>Direct care staff persons, ancillary staff persons, substitute personnel and regularly-scheduled volunteers shall be trained annually in the following areas:</p> <p>(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.</p> <p>(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.</p> <p>(3) Resident rights (under these</p>	<p>Direct care staff person B did not receive training in these topics during the training year October of 2009 to September of 2010.</p>	<p>08/30/11</p>	<p>1. Immediate Correction: Between October 2009 and Sept 2010, Staff B had not received training on various topics including, fire safety, emergency preparedness, resident rights, the Older Adult Protective Services Act, falls and accident prevention and new populations groups not previously served. Our prior policy had been to train all Direct Care Staff on the topics outlined above annually as required by the Department under 65g. However, our policy had been to train all employees at hire on the topics outlined, but not to repeat the training annually unless employee was designated as a "Direct Care Staff, ancillary staff person, substitute personnel and/or regularly-scheduled volunteers". We had not previously so designated our drivers. Consultation with the surveyors informed us that transportation employees are to be classified as such and subsequently, all three of our drivers have been so in-serviced (see <i>attached 6</i>)</p>	<p>Steps have been taken to correct violation; full compliance is not verifiable</p> <p><i>11-2-11</i> Date</p> <p><i>[Signature]</i> Initials (DPW)</p>

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME PLUSH MILLS, 501 PLUSH MILL ROAD WALLINGFORD, PA 19086		CURRENT LICENSE NUMBER 131040	
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SIGNATURE OF LEGAL ENTITY 	DATE 9-23-11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION 	DATE 10/4/11

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regulations). (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101—10225.5102). (5) Falls and accident prevention. (6) New population groups that are being served at the home that were not previously served, if applicable.	65g (cont.)		2. Community review: Our policy has been changed to include drivers in our annual training and to review each position within the community to designate them as "Direct Care Staff, ancillary staff person, substitute personnel or regularly-scheduled volunteers" and include those staff people in the annual training requirement tracking system which identifies the anniversary dates for our employees and the status of their annual training requirements.  3. Prevention in future: HR Director or designee will review staff training files annually and at hire for conformance with this section 65g including, but not limited to Fire Safety, Emergency Preparedness, Resident rights, The Older Adult Protective Service Act, Falls and accident prevention and new population groups being served.	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

5.1  
Page 5 of 15

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SIGNATURE OF LEGAL ENTITY <i>Megan Lonaley</i>		DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>
			DATE <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
	<i>b5g (cont.)</i>		4. Responsible for monitoring and compliance: HR Director or designee. Additionally the Executive Director reviews the training log monthly to ensure the proper training is being provided on a timely basis.	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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SIGNATURE OF LEGAL ENTITY  <i>Megan Longley</i>	DATE  <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION  <i>JL</i>	DATE  <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
85d Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.	There were no lids on 4 large trash receptacles in the main kitchen.	08/23/11	<p>1. Immediate Correction: The offending trash cans were provided appropriate lids by 08/23/11. The kitchen and servery staff were trained on keeping the trash cans covered at all times.</p> <p>2. Community review: As of 07/14/11 all trash receptacles in the kitchen or related to kitchen use were surveyed and provided with lids if missing. By 08/23/11 The kitchen and servery staff were trained on keeping the trash cans covered at all times. (See attached B.1)</p>	<p style="font-size: 1.5em; margin: 0;"><i>JL</i></p> <p style="font-size: 1.2em; margin: 0;"><i>11-23-11</i></p>

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

6.1  
Page 1 of 15

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		DATE <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
	<i>B5d (cont)</i>		<p>3. Prevention in future: Director of Dining Services or designee(s) will monitor the use of lids on each shift. Lids will be cleaned at intervals throughout the day and at the end of each evening along with the trash receptacles. This will be documented through a daily checklist for sanitary kitchen practices. (See attached B.2)</p> <p>4. Responsible for monitoring and compliance: Director of Dining Services or designee.</p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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			DATE <i>10/4/11</i>

REGULATION 55 Pa. Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
103e 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.	<p>There was one-half tray of mushrooms and one-fourth tin of red sauce not dated or labeled, found in the refrigerator in the main kitchen of the home.</p> <p>There was one plastic bin with cookies and two plastic bins with muffins in the main kitchen dry food storage area that were not labeled or dated.</p>	08/23/11	<p>1. Immediate Correction: The ½ tray of mushrooms, the ¼ tin of red sauce in the refrigerator and the one bin of cookies and two bins of muffins found without dates were immediately thrown out.</p> <p>2. Community review: All food was inventoried and dated as of 07/14/11. All stored food will have a label with the name of the food item and the date received.</p>	<p><i>[Signature]</i> 11-23-11</p>

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

71  
Page 5 of 15

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	<i>103e (cont.)</i>		<p>3. Prevention in future: The kitchen staff received in-servicing on existing policy C-350 Storage of Food in refrigeration and policy C-310 Food Safety as of 07/25/11 to ensure all kitchen and servery staff are trained in accordance with DPW code 103e that food is labeled and covered when it is received. (See attached C.1). Director of Dining Services or designee will be responsible for doing inventories to discard any outdated foods and make sure that all foods have been property labeled. Inventory will not be less frequently performed than weekly. Compliance will be documented through the daily checklist for standard sanitary kitchen practices (See attached C.2).</p> <p>4. Responsible for monitoring and compliance: Director of Dining Services or designee.</p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>	DATE <i>5-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>	DATE <i>10/4/11</i>

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105g1 To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryer after each use.	On 7/7/11, there was an accumulation of lint in the lint trap of the 2nd floor dryer.	08/28/11	<ol style="list-style-type: none"> <li>1. Immediate Correction: The lint was immediately removed for the offending 2<sup>nd</sup> floor dryer.</li> <li>2. Community review: This is the only dryer affected.</li> <li>3. Prevention in future: To ensure that lint is removed after each use reinforcement training was given on 07/20/11 and 07/27/11 for all direct care staff in the 2 hour Annual Mandatory Training course. (See attached D.1). Lint traps will be checked and documentation of compliance will be recorded on the weekly Facility Maintenance and Safety Checklist (See excerpt from Checklist attached D.2).</li> </ol>	<p style="text-align: center;">Steps have been taken to correct violation; full compliance is not verifiable</p> <p style="text-align: center;"><i>[Signature]</i> Date: <i>11-23-11</i> Initial(s) (DPW)</p>

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

2.1  
Page A of 15

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	<i>105g1 (cont.)</i>		<i>4. Responsible for monitoring and compliance: The Director of Nursing will check to ensure lint is being removed through routine unannounced spot checks of the lint trap two times a month.</i>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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SIGNATURE OF LEGAL ENTITY <i>Megan Lonigan</i>		DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>
			DATE <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
123c For a home serving 9 or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.	The emergency evacuation diagram on the 2nd floor did not include the line of travel to exit doors.	09/15/11	<ol style="list-style-type: none"> <li>1. Immediate Correction: The Fire Exit Signs required improved directional indicator arrows to reflect where to evacuate in the event of a fire. A meeting took place on 07/28/11 with the signage company to procure new improved signs (see attached K).</li> <li>2. Community review: These were the only evacuation signs affected within the community.</li> <li>3. Prevention in future: New signs have been ordered upon approval of the plan of correction and will be immediately installed estimated to be not later than 09/15/11. All future signs will be reviewed for compliance.</li> <li>4. Responsible for monitoring and compliance: Executive Director or designee.</li> </ol>	<i>[Signature]</i> 11-2-11

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME PLUSH MILLS, 501 PLUSH MILL ROAD WALLINGFORD, PA 19086		CURRENT LICENSE NUMBER 131040		
INSPECTION DATES (Include all dates of the inspection) 07/06/2011		REGIONAL REPRESENTATIVE Roslyn Brewer, Justin Trupp		
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <i>Megan Longley, Executive Director</i>				
SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>		DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>RL</i>	DATE <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY																																																																	
132f Alternate exit routes shall be used during fire drills.	<p>The home's fire drill log for 2010 and 2011 did not indicate that alternate exit routes were used during fire drills.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="text-align: left;">Mont</th> <th style="text-align: left;">Date</th> <th style="text-align: left;">Time</th> <th style="text-align: left;">Evac. Time</th> <th style="text-align: left;">FSE</th> </tr> </thead> <tbody> <tr><td>Jan</td><td>01/20/2010</td><td>08:00 AM</td><td>5min</td><td>No</td></tr> <tr><td>Feb</td><td>02/17/2010</td><td>04:30 PM</td><td>6 min 10sec</td><td>No</td></tr> <tr><td>Mar</td><td>03/23/2010</td><td>11:15 AM</td><td>5min</td><td>No</td></tr> <tr><td>Apr</td><td>04/01/2010</td><td>07:15 PM</td><td>4min 30 sec</td><td>No</td></tr> <tr><td>May</td><td>05/29/2010</td><td>06:00 PM</td><td>4 min 20 sec</td><td>Yes</td></tr> <tr><td>Jun</td><td>06/13/2010</td><td>01:16 PM</td><td>5min</td><td>No</td></tr> <tr><td>Jul</td><td>07/08/2010</td><td>01:30 PM</td><td>4min 50 sec</td><td>No</td></tr> <tr><td>Aug</td><td>08/24/2010</td><td>01:15 PM</td><td>4min 55 sec</td><td>No</td></tr> <tr><td>Sep</td><td>09/15/2010</td><td>09:00 AM</td><td>4min 10 sec</td><td>No</td></tr> <tr><td>Oct</td><td>10/22/2010</td><td>11:00 AM</td><td>4min 15 sec</td><td>No</td></tr> <tr><td>Nov</td><td>11/17/2010</td><td>11:00 PM</td><td>4min 55 sec</td><td>No</td></tr> <tr><td>Dec</td><td>12/02/2010</td><td>07:15 PM</td><td>4min 38 sec</td><td>No</td></tr> </tbody> </table>	Mont	Date	Time	Evac. Time	FSE	Jan	01/20/2010	08:00 AM	5min	No	Feb	02/17/2010	04:30 PM	6 min 10sec	No	Mar	03/23/2010	11:15 AM	5min	No	Apr	04/01/2010	07:15 PM	4min 30 sec	No	May	05/29/2010	06:00 PM	4 min 20 sec	Yes	Jun	06/13/2010	01:16 PM	5min	No	Jul	07/08/2010	01:30 PM	4min 50 sec	No	Aug	08/24/2010	01:15 PM	4min 55 sec	No	Sep	09/15/2010	09:00 AM	4min 10 sec	No	Oct	10/22/2010	11:00 AM	4min 15 sec	No	Nov	11/17/2010	11:00 PM	4min 55 sec	No	Dec	12/02/2010	07:15 PM	4min 38 sec	No	08/10/11	<p>1. Immediate Correction: The home's fire drill log for 2010 and 2011 did not indicate that alternate exit routes were used during fire drills. The fire drill sheets only indicated middle, north and south exit routes. The fire drills commencing September, 2011 will, per DPW recommendations, include alternate exit routes and the Fire Drill Record documentation sheets will now indicate one side, either side or middle exit routes to so illustrate variation in drills.</p> <p>2. Community review: This cannot be retroactively amended. This can only be amended in future fire drills.</p>	<p style="text-align: center; font-size: 2em;"><i>ggy</i></p> <p style="text-align: center; font-size: 1.5em;">11-23-11</p>
Mont	Date	Time	Evac. Time	FSE																																																																	
Jan	01/20/2010	08:00 AM	5min	No																																																																	
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VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

10.1  
Page 3 of 15

NAME AND ADDRESS OF PERSONAL CARE HOME PLUSH MILLS, 501 PLUSH MILL ROAD WALLINGFORD, PA 19086		CURRENT LICENSE NUMBER 131040	
INSPECTION DATES (include all dates of the inspection) 07/06/2011		REGIONAL REPRESENTATIVE Roslyn Brewer, Justin Trupp	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <i>Megan Longley, Executive</i>			
SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>	DATE <i>8-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>Ki</i>	DATE <i>10/4/11</i>

REGULATION 55 Pa. Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
	<i>132f (cont.)</i>		<p>3. Prevention in future: The Executive Director completes the form and will use the aforementioned revised descriptions. The Fire Drill logs are and will continue to be reviewed monthly.</p> <p>4. Responsible for monitoring and compliance: The Executive Director.</p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <p style="text-align: center; font-size: 1.2em;"><i>Megan Longley, Executive Director</i></p>			
SIGNATURE OF LEGAL ENTITY <i>Megan Longley</i>	DATE <i>9-23-11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>Le</i>	DATE <i>10/4/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
183e 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.	On 7/7/2011, on the 2nd floor, two loose pills were found in the medication storage dresser, in the far right bottom portion of the drawer.	07/28/11	<ol style="list-style-type: none"> <li>1. Immediate Correction: The two loose pills found in the medication storage dresser during the survey were immediately destroyed and the cart was thoroughly cleaned by the charge nurse and no additional violation of medication storage per 183e were identified.</li> <li>2. Community review: This was the only cart affected.</li> </ol>	<p style="font-size: 0.8em;">Steps have been taken to correct violation; full compliance is not verifiable</p> <p style="font-size: 0.8em;">11-23-11 Date</p> <p style="font-size: 0.8em;"><i>[Signature]</i> Initials (DPW)</p>

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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	<i>183e (cont.)</i>		<p>3. Prevention in future: Training was given to all care staff on 07/20/11 and 07/27/11 reviewing policy number F-150 AND F-160 Storage and Disposal of Medications and Medical Supplies as well as Regulation 183e in the two hour Annual Mandatory Training course. (See attached E.1). The Director of Nursing or designee will perform a monthly Medication Audit (See attached E.2). The Medication audit, as a result of the survey, has specifically included documentation for proper storage and labeling of medications.</p> <p>4. Responsible for monitoring and compliance: Director of Nursing or designee.</p>	

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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			DATE <i>10/4/11</i>

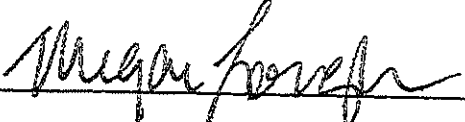

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183f1 Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person,	<p>Resident #1's Tramadol 50 mg was in the medication cart. This medication was discontinued by the doctor on 4/14/11.</p> <p>There were 3 blister packs of Lorazepam with various instructions for resident #2 in the medication cart. All of these were discontinued by the doctor on 5/26/11.</p> <p>One blister pack of Acetaminophen 325 mg for resident #4 was in the medication cart. This medication was discontinued by the doctor on 6/10/2010.</p>	07/28/2011	<p>1. Immediate Correction: The three discontinued medications (Tramadol, Lorazepam and Acetaminophen) found on the medication cart were immediately removed and returned to the pharmacy by the charge nurse.</p> <p>2. Community review: The cart was audited in conjunction with the MAR's to ensure all discontinued medications had been removed from the cart.</p>	<i>JL</i> 11-23-11


VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.			<p>3. Prevention in future: Training was given to all care staff on 07/20/11 and 07/27/11 reviewing policy number F-150 Storage and Disposal of Medications and Medical Supplies as well as Regulation 183fl in the two hour Annual Mandatory Training course. (See attached H.1). The Director of Nursing or designee will perform a monthly Medication Audit (See attached H.2). The Medication audit, as a result of the survey, has specifically included documentation for proper storage and labeling of medications.</p> <p>4. Responsible for monitoring and compliance: Director of Nursing or designee.</p>	

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185a 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.	Resident #5 is prescribed Docusate Sodium 100 mg, twice daily as needed. This medication is not available in the home for administration.  Resident #6 is prescribed Triamcinoilone Cream twice daily as needed. This medication is not available in the home for administration.	07/28/2011	1. Immediate Correction: Two PRN treatments for residents were discovered to be unavailable in the community for administration. The PRN treatments were delivered to the community the day of the survey 07/14/11.  2. Community review: The cart was audited in conjunction with the MAR's to ensure that all PRN treatments prescribed are available in the community.	 11-23-11

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

12/1  
Page 1 of 15

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	<i>185a (cont.)</i>		<p>3. Prevention in future: Training was given to all care staff on 07/20/11 and 07/27/11 reviewing policy number F-150 Storage and Disposal of Medications and Medical Supplies as well as Regulation 185A in the two hour Annual Mandatory Training course. (See attached J.1). The Director of Nursing or designee will perform a monthly Medication Audit (See attached J.2). The Medication audit, as a result of the survey, has specifically included documentation for proper storage and labeling of medications.</p> <p>4. Responsible for monitoring and compliance: The Director of Nursing or designee.</p>	

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224a A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.	The pre-admission screening documentation for residents #6 and #7 did not indicate the date the pre-admission screening was completed.	07/28/11	<ol style="list-style-type: none"> <li>1. Immediate Correction: The pre-admission screening documentation for residents #6&amp;#7 did not indicate the date the pre-admission screening was completed. As a result of the survey, the Director of Nursing recorded a late entry of the dates for the pre-admission screen based on the date recorded elsewhere on the screening form.</li> <li>2. Community review: All resident files were reviewed for record compliance with 224a by 07/28/11.</li> <li>3. Prevention in future: Director of Nursing or designee completes all Pre-Admission Screening forms and will ensure appropriate dating in all locations on the form.</li> <li>4. Responsible for monitoring and compliance: Director of Nursing or designee. Executive Director will perform periodic chart audits to ensure compliance.</li> </ol>	<i>RL</i> 11-23-11