COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **THE NEW HERITAGE TOWERS, INC.**
(LEGAL ENTITY)

To operate **HERITAGE TOWERS**
(NAME OF FACILITY OR AGENCY)

Located at **200 VETERANS LANE, DOYLESTOWN, PA 18901**
(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 **75** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

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 **July 5, 2013** until **July 5, 2014**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 127180

Robert E. Robinson
ISSUING OFFICER

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

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

JUL 0 5 2013

Mr. Steven Cherry, Executive Director
The New Heritage Towers, Inc.
Heritage Towers
200 Veterans Lane
Doylestown, Pennsylvania 18901

Dear Mr. Cherry:

As a result of the Department of Public Welfare's (Department) licensing inspection on February 14, 2013, February 15, 2013, May 1, 2013, May 17, 2013 and June 17, 2013, 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 Human Services Licensing so that compliance can be verified.

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

Sincerely,

Ronald Melusky
Director

Enclosures
License
Violation Report

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

PCH Name: HERITAGE TOWERS	License Number: 127180
Address: 200 VETERANS LANE, DOYLESTOWN, PA 18901	County: Bucks
Administrator: Donyale Showers	Region: SOUTHEAST
Legal Entity Name: THE NEW HERITAGE TOWERS INC	
Legal Entity Address: 200 VETERANS LANE, DOYLESTOWN, PA 18901	

Certificate(s) of Occupancy

C-2 LP
06/08/2001
PA L&I

Staffing Hours

Resident Support:	Total Daily Staff: 74	Waking Staff: 56
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

02/14/2013: McHale, Christine; Miller, Chevon
02/15/2013: McHale, Christine; Miller, Chevon

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers:	Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 75	Number of Residents who:
Number of Residents Served: 59	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 59
Area:	Have Mental Illness: 0
Secured Dementia Unit Capacity, if Applicable:	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, if applicable:	Have a Mobility Need: 15
Number of Current Hospice Residents: 0	Have a Physical Disability: 1
Number of Hospice Residents in past year:	

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.25(a)(1) - Prior to admission, or within 24 hours after admission, a written resident-home contract (contract) between the resident and the home shall be in place.

2a. DESCRIPTION OF VIOLATION
Residents #7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 and 21 did not have a resident - home contract completed.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The New Heritage Towers is a Continuing Care Retirement Community that has independent living apartments, a Personal Care Home (Heritage Towers), and a Skilled Nursing Facility. Residents # 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, and 20 are Independent living residents being served by Wesley Enhanced Living Doylestown Home Care Agency (License #18563601), a home care agency which is separately licensed by the Pennsylvania Department of Health. Each resident has a home care service agreement as required by Title 28 Part IV Subpart H Chapter 611.

Heritage Towers is in disagreement with the violation because the cited residents live on upper floors and receive services under a PA DOH Home Care License, in cooperation with a plan to have all DPW licensed Personal Care services provided on floors 2 and 3 of the CCRC high-rise building. This arrangement had tacit and verbal approval by the local licensing office. A change in this approval came through a telephone call from the local office on (about) 3/1/2013 indicating that due to a new determination by DPW, additional violations would be added to those pertaining to the 2/14/2013-2/15/2013 survey, that would require consideration of persons served under the Home Care license would need to follow all DPW Personal Care rules and regulations. We believe dual licensure is unnecessary for wellbeing and appropriate serving clients and that the said division by floor is appropriate.

However, if the violation remains, the plan to correct is as follows: The Personal Care Administrator will prescreen Residents #7, 8, 9, 10, 11, 12, 13 14, 15, 16, 17, 18, 19, and 20 and present the appropriate residents with the option of becoming a resident of Heritage Towers Personal Care Home or remaining independent. The PC Administrator will prepare resident home contracts for each resident who chooses to become a resident of the personal care home, and put it in place within 24 hours after admission. All prescreening and resident home contracts will be completed by April 10, 2013. Going forward, WEL Doylestown residents who request assistance with ADL's will be pre-screened and will have Resident Home Contracts established in adherence with the current personal care admission procedure. In order to ensure compliance the PC Administrator will review the admission documents of all personal care residents to verify prescreening and resident home contract has been completed, and report findings in the Quality Management Program Meetings.

Resident #15 is a resident of the Heritage Towers Personal Care Home, and has a Personal Care Home Agreement in place effective 2/11/2013. Resident #21 discontinued receiving services effective 1/16/2013. Corrections are not required for Residents #15 & 21.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Danyelle Shawers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Danyelle Shawers, Personal Care Administrator — Date 4/1/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 6/7/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.25(b) - 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.

2a. DESCRIPTION OF VIOLATION

- The contract for resident #1 was not signed by the resident. Additionally, the home had a rate increase effective 1/1/13. A letter dated 11/16/12 documented this change and was not signed by the resident.

- The contract for resident #2 dated 11/30/12 was not signed by the resident. The resident's contract stated that the resident was unable to sign. The resident was able to sign their support plan dated 12/8/12. The home did not make any additional attempts to have the resident sign the contract. Additionally, the home had a rate increase effective 1/1/13. A letter dated 11/30/12 documented this change and was not signed by the resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident #1 has a Power of Attorney. Care services and cost information was discussed with the resident for verbal authorization. Resident #1 directs staff to obtain signatures from the Power of Attorney for documents that have any financial references. The Power of Attorney for Resident #1 signed the resident-home contract on the day before admission to the personal care home, and signed the 2013 Rate Increase Notice on 11/21/2012. The resident-home contract and the 2013 Rate Increase Notice for Resident #1 was signed by the resident on 2/22/2013.

Resident #2 has a Power of Attorney. Care services and cost information was discussed with the resident. Documentation on Resident # 2 resident-home contract indicated resident was "unable to sign" the document when it was presented for signature. The Power of Attorney for Resident #2 signed the resident-home contract and the 2013 Rate Increase Notice on 11/30/2012, the day of admission. Resident #2 is currently receiving care in a skilled nursing facility. When Resident #2 returns to Heritage Towers Personal Care Home, we will make 3 additional attempts within 7 days beginning the day of her arrival to obtain a signature acknowledging receipt of these documents, and document efforts to obtain signature.

Since July 2012, the current quality review procedure has been effective at verifying presence of the required admission documents on 100% of newly admitted residents. In order to ensure compliance with obtaining resident signatures or documenting multiple attempts to obtain resident signatures, the quality review of new admission documentation will flag documents that are not signed by residents. Personal Care Staff will make 3 additional attempts within 7 days beginning the day of admission to obtain a signature on required documents. If a resident refuses to sign or is unable to sign, efforts to obtain the signature will be documented in detail and include a witness signature. The Personal Care Administrator will monitor and report performance in the Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Danyale Showers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Danyale Showers, Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/16/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.25(g) - A copy of the signed contract shall be given to the resident and a copy shall be filed in the resident's record.

2a. DESCRIPTION OF VIOLATION
A copy of the contract for resident #1 in the resident's record was incomplete and only contained four of approximately 30 pages of the contract.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The missing pages of the resident home contract for Resident #1 were placed in the resident's record on 2/15/2013.

Since July 2012, the current quality review procedure has been effective at verifying presence of the required admission documents on 100% of newly admitted residents. The Personal Care Administrator monitors the effectiveness of this process for verifying a copy of the signed contract is filed in the residents' records by reviewing the records of newly admitted residents and tracking performance in the Quality Management Program meetings.
The Personal Care Administrator will monitor and report performance in the Quality Management Program meetings.

The Personal Care Administrator completed an audit of resident records for residents admitted since January 1, 2012 to identify admissions agreement items that may be missing from residents' records, including contracts, complaint procedures, residents' rights, fee schedules, and civil rights compliance notices. Items are missing will be reviewed with each respective resident and/or the Power of Attorney, with appropriate signature obtained. If efforts to obtain a signature are not successful, we will provide detailed documentation of efforts and obtain a witness signature. All residents' records will be complete by 3/29/2013.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Shavers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Shavers, Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/16/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.41(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 § 2600.41(d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

2a. 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.

-Residents #7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 and 21 did not sign a statement acknowledging receipt of a copy of the resident rights and complaint procedures.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Documentation on Resident # 2 resident-home contract indicated she was "unable to sign" the document when it was presented for signature. Receipt of Residents Rights and Complaint Procedure was acknowledged by the Power of Attorney on the day of admission. Resident #2 is currently receiving care in a skilled nursing facility. When Resident #2 returns to Heritage Towers Personal Care Home, we will make 3 additional attempts within 7 days beginning the day of her arrival to obtain a signature acknowledging receipt of these documents, and document efforts to obtain signature.

Residents # 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, and 20 are independent living residents being served by Wesley Enhanced Living Doylestown Home Care Agency (License #18563601), a home care agency which is separately licensed by the Pennsylvania Department of Health. Documents provided for home care agency clients comply with the regulations that govern home care agencies - Title 28 Part IV Subpart H Chapter 611. These regulations do not require home care clients to provide signatures to acknowledge receipt of documents.

Heritage Towers is in disagreement with the violation because the cited residents live on upper floors and receive services under a PA DOH Home Care License, in cooperation with a plan to have all DPW licensed Personal Care services provided on floors 2 and 3 of the CCRC high-rise building. This arrangement had tacit and verbal approval by the local licensing office. A change in this approval came through a telephone call from the local office on (about) 3/1/2013 indicating that due to a new determination by DPW, additional violations would be added to those pertaining to the 2/14/2013-2/15/2013 survey, that would require consideration of persons served under the Home Care license would need to follow all DPW Personal Care rules and regulations. We believe dual licensure is unnecessary for wellbeing and appropriate serving clients and that the said division by floor is appropriate.

However, if the violation remains, the plan to correct is as follows: By 4/10/2013, the Personal Care Administrator will prescreen Residents #7, 8, 9, 10, 11, 12, 13 14, 15, 16, 17, 18, 19, and 20 and present the appropriate residents with the option of becoming a resident of Heritage Towers Personal Care Home. The PC Administrator will prepare resident home contracts for each resident who chooses to become a resident of the personal care home, and put it in place within 24 hours after admission. A copy of the Residents Rights and Complaint Procedure is provided with each resident home contract. The PC Administrator will obtain resident and, if applicable, designated person signatures acknowledging receipt of the Residents Rights and Complaint Procedures. In order to ensure compliance the PC Administrator will review the admission documents of each resident who enroll in the personal care home to verify appropriate documentation of acknowledgments, and report findings in Quality Management Program Meeting.

Resident #15 became a resident of the Heritage Towers Personal Care Home effective 2/11/2013, and has a signed Residents' Rights and Complaint Procedures. Resident #21 discontinued services 1/16/2013. Corrections not needed for #15 & 21.

Repeat Violation: No | Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Shewers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Shewers Personal Care Administrator

Date 4/1/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by FW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.60(a) - Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION

The home's 11/19/12 letter from Fire and Life Safety Solutions that reads in part, "In my opinion residents in your building that are not in areas affected by smoke and flames are in areas of refuge. These residents must still be removed from their rooms to be considered as participating in the drill." On 2/15/13 at 5:00 AM, the Department observed a fire drill conducted at the home. There were four staff persons present in the home at that time. The staff persons were able to evacuate residents from the area "affected" by simulated smoke and flames within the time specified by the fire safety experts letter dated 5/10/12. Following the evacuation from the simulated affected area, it was discovered that several residents in the unaffected areas did not leave their rooms because they were unable to do so without assistance. There was insufficient staffing to ensure that all residents would evacuate and participate in the event of an actual fire.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The New Heritage Towers is a Continuing Care Retirement Community that has independent living apartments, a Personal Care Home (Heritage Towers), and a Skilled Nursing Facility. All (100%) of Personal Care Home residents participated in the Fire Drill conducted on February 15, 2013. Residents who did not evacuate to fire safe areas in the drill are independent living residents being served by Wesley Enhanced Living Doylestown Home Care Agency (License #18563601), a home care agency which is separately licensed by the Pennsylvania Department of Health. Title 28 Part IV Subpart H Chapter 611 which regulates home care services does require residents to evacuate during fire drills.

On (about) 3/1/2013, the local licensing office of DPW made a new determination: Independent Living residents receiving personal care services by Wesley Enhanced Living Doylestown Home Care Agency must have services delivered in compliance with Chapter 2600 Personal Care Homes. The local licensing office indicated additional violations would be added to those pertaining to the 2/14/2013-2/15/2013 survey.

The PC Administrator will review the staffing schedule each week to ensure that adequate staff is assigned to meet the needs of all of the personal care home residents by 5/30/13. Documentation will be maintained to verify with the Department that there is adequate staffing for all personal care residents that have service needs or require assistance to evacuate during a fire drill. All residents receiving personal care services through the Home Care license will be assessed to determine their care needs and a Personal care contract will be initiated within 24 hours of the pre-screening assessment by 6/10/13. The PC Administrator will plan for staff training on evacuation procedures inclusive of in-services, walkthrough drills for staff, and fire drills involving residents. The PC Administrator will collaborate with the fire safety expert to develop a plan and schedule for conducting fire drills at an increased frequency over the next 3 months, or until the evacuation time goal is achieved on the 11pm - 7am shift.

The Personal Care Administrator and the Director of Facilities will monitor adherence to fire drill procedures utilizing the Quality Management Program Meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Donyale Shower			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Donyale Shower, Personal Care Administrator		**Date**	5/15/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/16/13 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 6/7/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.65(b) - Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.

2a. DESCRIPTION OF VIOLATION

Ancillary staff person A, hired on 4/15/12 did not receive orientation in the home's emergency medical plan and reporting of reportable incidents.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Ancillary staff person A will complete training on the Heritage Towers Personal Care Home Emergency Medical Plan and the Procedure on Reporting Reportable Incidents by 3/29/2013.

By 3/15/2013, the Personal Care Administrator will complete a 100% audit of all Personal Care Ancillary Staff records to identify and train staff who have not received training in the Emergency Medical Plan and the Procedure on Reporting Reportable Incidents. Ancillary Staff will complete training by 3/29/2013.

In December 2012, the Personal Care Administrator began participating in new hire orientation for ancillary staff. During this orientation, the Personal Care Administrator or designee orients all new staff to the Heritage Towers Personal Care Home emergency Medical Plan and the Procedure on Reporting Reportable Incidents. The Personal Care Administrator will monitor the effectiveness of this process for educating new ancillary staff orientation to the Emergency Medical Plan and Reporting Reportable Incidents within their first 40 scheduled working hours by reviewing staff training records and tracking performance in the Quality Management Program meetings.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/16/2012		

Signature of Legal Entity Representative (Required on EVERY Page) Dorothy Mowers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dorothy Mowers, Personal Care Administrator — **Date** 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
(3) Resident rights.
(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.

2a. DESCRIPTION OF VIOLATION

- Direct care staff persons B and C did not receive training in fire safety by a fire safety expert, emergency preparedness, and the Older Adult Protective Services Act during training year 2012.

- Ancillary staff persons D and E did not receive training in fire safety by a fire safety expert and emergency preparedness during training year 2012.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Fire Safety Training that was completed by Direct Care Staff B and C and Ancillary Staff D and E was not conducted by a fire safety expert. By 4/14/2013, Direct Care Staff and Ancillary Staff will receive Fire Safety Training by a Fire Safety expert or by a staff person trained by a Fire Safety Expert.

The Personal Care Administrator will review the fire safety qualifications of trainers of fire safety prior to enlisting the trainer to lead fire safety training.

The summary description of the training on Abuse completed by Direct Care Staff B and C did not specify that the education material included the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102). By 4/14/2013, all Direct Care Staff and Ancillary Staff will receive training on the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).

The Personal Care Administrator will review the course description to verify that it includes education on the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102) prior to utilizing the course for training staff.

By 3/29/2013, Direct Care Staff B and C and Ancillary Staff D and E will receive training on the facility Fire and Emergency Disaster Plans and Procedures. Annually, the Personal Care Administrator will lead a review of the Fire and Emergency Disaster Plans and Procedures during the first quarter of each year.

The Personal Care Administrator will monitor staff completion of annual education requirements by reviewing staff training records and tracking performance in the Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Knuckles, Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.82(c) - Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

2a. DESCRIPTION OF VIOLATION
A bottle of 'Micro Munchers Deodorizer', with a manufacturer's label indicating "If ingested drink large quantity of water and get medical aid," was found unlocked and accessible to residents in the eighth floor 'housekeeping closet.' Residents of the home, including residents #2, #3, and #4, have not been assessed capable of recognizing and using poisons safely.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The lock on the housekeeping closet was engaged but not functioning properly, allowing it to be bypassed with moderate effort. The malfunctioning lock was replaced on 2/14/2013.

By 3/15/2013, housekeeping staff will be educated on the importance of securing poisonous materials in the home. The education will focus attention on:

- Reporting malfunctioning locks or other conditions that may allow security measures to be bypassed
- If a storage space cannot be secured from resident access, poisonous materials will be removed from that space.
- Signs will be posted in targeted locations throughout the building reminding staff to immediately report malfunctioning locks and any condition that may present a hazard.

In order to ensure ongoing compliance:

A designee of the Director of Facilities completes a physical plant check daily, which includes checking the locks on community doors. The Director of Facilities will educate designees conducting such checks to evaluate whether a malfunction exists that will allow a lock to be bypassed with moderate effort. The Director of Facilities will report to the Personal Care Administrator each episode of finding poisonous material that is accessible by residents. Additional corrections and monitoring will be developed and implemented until the home consistently achieves 100% compliance on a daily safety checks.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Douglas Stevens

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Douglas Stevens Personal Care Administrator — Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.103(g) - Food shall be stored in closed or sealed containers.

2a. DESCRIPTION OF VIOLATION
A bag of mini chicken cordon bleu, a bag of hamburgers, and a bag of flounder fillets in the large walk-in freezer in the home's main kitchen were opened and unsealed.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The unsealed food items were labeled or discarded on 2/15/2013.

On 2/19/2013, the Director of Dining Services educated food service staff on the proper sealing and labeling of frozen foods. The Director of Dining Services monitors staff adherence to proper sealing and labeling of open frozen food items. The Director of Dining Services will report the findings to the Personal Care Administrator each month for the next 3 months or until 100% compliance is achieved. The frequency on ongoing monitoring will be determined through the Quality Management Program.

The director of Dietary Services will monitor the food stored on a weekly basis to insure all food is properly sealed. SW

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Showers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Showers, Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.107(d) - The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

2a. DESCRIPTION OF VIOLATION
The home's written emergency procedures have not been submitted to the municipal emergency management agency since 2010.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Personal Care Administrator submitted a copy of the Fire and Emergency Disaster Plans and Procedures to the Bucks County Emergency Management Director on 2/18/2013.

Annually, the Personal Care Administrator a copy of the Fire and Emergency Disaster Plans and Procedures to the Bucks County Emergency Management Director during the first quarter of each year. Completion of this task annual task will be validated using the Quality Management Program.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Dompie Shavers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dompie Shavers, Personal Care Administrator — Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.123(d) - If the home serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

2a. DESCRIPTION OF VIOLATION

The home serves residents with mobility needs above grade level. The home's 5/10/12 letter from Fire and Life Safety Solutions designates the home's "fire towers" as fire-safe areas. A supplemental letter dated 11/19/12 reads in part, "the openings to the fire towers are rated for ninety minutes of protection and of non-combustible construction, creating a two-hour rated enclosure." On 2/15/13 at 5:00 AM, the Department observed a fire drill conducted at the home. During the drill, the simulated fire was on the second floor in an area that required the residents to evacuate to one of the fire towers. When all of the residents who evacuated to this location were in the fire tower, the door to the tower could not be closed such that in the event of an actual fire, residents would have been exposed to fire and smoke conditions. This area does not meet the fire safety expert's requirements to establish it as a fire-safe area.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Fire Safety Expert reviewed the notes from the Fire Drill conducted on February 15, 2013, and determined that staff did not follow correct evacuation procedure. The Fire Safety Expert determined that the three stair towers and the areas on either side of the fire doors that may be used as refuge areas for your residents. Each area has the capacity to hold more than 100% of your current resident capacity. Based on the scenario presented during this fire drill, residents on the 2nd floor in the area where the fire was were taken into stair tower A. Because residents were not moved to the lower landings during the drill the door to the stair tower could not be closed.

The Fire Safety Expert evaluated all of our evacuation procedures has provided new, detailed instructions on evacuating all PC residents to fire safe designated meeting areas within the maximum allowable time of 13 minutes. By May 24, 2013, PC Administrator and other key members of the Quality Management Program will determine the appropriate staffing level to provide for supervision of personal care residents within the designated meeting areas.

By June 10, 2013, The PC administrator will develop a schedule for staff training on new evacuation procedures inclusive of in-services, walkthrough drills for staff, and fire drills involving residents. The PC Administrator will collaborate with the fire safety expert to develop a plan and schedule for conducting fire drills at an increased frequency over the next 3 months, or until the evacuation time goal is achieved on the 11pm - 7am shift.

The Personal Care Administrator and the Director of Facilities will monitor adherence to fire drill procedures utilizing the Quality Management Program.

Training will be conducted with residents and staff on the proper techniques on staging residents on the fire tower stairs, safely, to ensure the doors to the tower are able to close to protect the residents, in accordance with the fire safety expert.

Repeat Violation: No	Date(s) of Previous Violation(s):		

Signature of Legal Entity Representative (Required on EVERY Page) Danyele Showers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Danyele Showers, Personal Care Administrator

Date 5/10/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/15/13 (Date)

The above plan of correction was approved by BM (Initials)

Plan of correction implementation status as of 6/18/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.130(b) - The smoke detectors specified in § 2600.130(a) shall be located in hallways.

2a. DESCRIPTION OF VIOLATION
- There is no smoke detector in the hallway within 15 feet of resident bedroom 407.

- There is no smoke detector in the hallway within 15 feet of resident bedroom 818.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

On 2/14/2013, one smoke detector was placed in the hallway within 15 feet of resident bedroom 407 and one smoke detector was placed in the hallway within 15 feet of resident bedroom 818.

These two residents are the only bedrooms outside of the 2nd and 3rd floor utilized by Personal Care Home Residents. All bedrooms on 2nd and 3rd floors have smoke detectors within 15 feet.

The operation of these two new smoke detectors will be included on the monthly monitoring by the Director of Facilities and reported to the Personal Care Home Administrator.

By 3/15/2013, "smoke detector within 15 ft bedroom door" will be added to the personal care bedroom checklist that is currently used for verifying bedrooms comply with regulations. Direct Care Staff use this checklist to inspect all new bedrooms and periodically existing bedrooms. The Personal Care Administrator will notify the Director of Facilities to add the smoke detectors within 15 feet of new personal care residents bedrooms outside of 2nd and 3rd floors and to include these smoke detectors on routine monthly monitoring.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Douglas Shawn

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Douglas Shawn Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by EW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

2a. DESCRIPTION OF VIOLATION
During the Department's observation of a fire drill conducted at the home on 2/15/13 at 5:00 AM, several residents in the unaffected areas did not evacuate to the designated meeting place within the fire-safe area. The home's 11/19/12 letter from Fire and Life Safety Solutions that reads in part, "In my opinion residents in your building that are not in areas affected by smoke and flames are in areas of refuge. These residents must still be removed from their rooms to be considered as participating in the drill."

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The New Heritage Towers is a Continuing Care Retirement Community that has independent living apartments, a Personal Care Home (Heritage Towers), and a Skilled Nursing Facility. All (100%) of Personal Care Home residents participated in the Fire Drill conducted on February 15, 2013. Residents who did not evacuate to fire safe areas in the drill are independent living residents being served by Wesley Enhanced Living Doylestown Home Care Agency (License #18563601), a home care agency which is separately licensed by the Pennsylvania Department of Health. Title 28 Part IV Subpart H Chapter 611 which regulates home care services does require residents to evacuate during fire drills.

On (about) 3/1/2013, the local licensing office of DPW made a new determination: Independent Living residents receiving personal care services by Wesley Enhanced Living Doylestown Home Care Agency must have services delivered in compliance with Chapter 2600 Personal Care Homes. The local licensing office indicated additional violations would be added to those pertaining to the 2/14/2013-2/15/2013 survey.

The PC Administrator will ensure that all residents identified with personal care needs are evacuated to a fire safe area, during all fire drills with staff supervision, by holding additional sleeping time drills over the next 3 months. The Director of Facilities will hold the unannounced drills and maintain documentation of the drills. All residents receiving personal care services through the Home Care license will be assessed to determine their care needs and a Personal Care contract will be initiated within 24 hours of the pre-screening assessment by 6/10/13. The PC administrator will plan for staff training on evacuation procedures inclusive of in-services, walkthrough drills for staff, and fire drills involving residents. The PC Administrator will collaborate with the fire safety expert to develop a plan and schedule for conducting fire drills at an increased frequency over the next 3 months, or until the evacuation time goal is achieved on the 11pm - 7am shift.

The Personal Care Administrator and the Director of Facilities will monitor adherence to fire drill procedures utilizing the Quality Management Program Meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Shavers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Shavers, Personal Care Administrator — Date 5/15/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/15/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 6/18/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.132(j) - Elevators may not be used during a fire drill or a fire.

2a. DESCRIPTION OF VIOLATION
During the Department observed fire drill held on 2/15/13 residents were evacuated with the use of the home's elevator located on the 8th and 4th floors.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Effective immediately, Personal Care Home Staff in the community have been instructed to not utilize the elevator during fire drills or fire. Staff have been instructed to utilize stairs to access patients on the 4th and 8th floors of the home, and to supervise residents in fire safe areas on the respective floors.

We are in consultation with a different fire safety expert, to redesign our fire drill protocols as well as our building configuration. Within 30 days, we will work with our fire safety expert to evaluate all of our fire evacuation procedures to ensure the most expeditious and safe route(s) are used to ensure the safety of our residents. We will submit changes, if any, to the Department based upon the outcome or our expert's report.

The April 2013 fire drill will be conducted without using the elevator. The Personal Care Administrator will adjust staffing levels as needed to ensure safe evacuation during fire drills and fires, and to supervise residents in fire safe areas on the respective floors.

Monthly review of fire drill performance will include observing for use of elevators by staff. The Personal Care Administrator and the Director of Facilities will monitor adherence to fire drill procedures utilizing the Quality Management Program.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Douglas Shreeves

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Douglas Shreeves Personal Care Administrator — Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
On 2/14/13, medications prescribed for individual #5, who is not a current resident of the home, was located in the home's nursing area on the second floor.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Medications belonging to Individual #5 were stored in a lock and labeled box within the locked medication room.
The locked and labeled box for Individual #5 was removed from the Personal Care Home on 2/15/2013.
Direct Care Staff were educated that only current Personal Care Residents' medications are permitted to be in the Personal Care medication room.
An inspection of the Personal Care medication room completed by the Personal Care Administrator on 3/11/2013 revealed that all medications present were for current Personal Care Residents. By 4/30/2013, the Personal Care Administrator will conduct 3 additional unannounced environmental surveillances of the medication room to verify staff adherence. The results of the surveillances will be reported in the Quality Management Program. Additional corrective actions may be developed as necessary to ensure 100% compliance.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Dwayne Shawers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dwayne Shawers, Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 6/4/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION
- Resident #2 is prescribed Aspirin chewable 81 mg. The home is administering Aspirin enteric coated 81 mg.

- Resident #3 is prescribed Digoxin 0.125 mg with the instructions to take the resident's pulse first. On 2/11/13 the medication was administered without taking the resident's pulse.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

On 2/15/2013, the Home obtained chewable 81mg Aspirin for Resident #2 from the pharmacy.
Medication Technicians were educated to distinguish the difference between medications ordered in different forms, including "chewable" and "enteric coasted" medications. When medications are received from the pharmacy or family members, the intake process will now include confirming the form of the medication, if specified in the physician order, matches the physician order. Medications that are prescribed to be administered in a specific form (ex. chewable) will not be accepted in any other form unless permitted by physician order.
The current medication audit procedure results in 100% of medications being audited each month utilizing the Medication Audit tool. By 3/29/2013, the Medication Audit tool will be amended to include verifying the form of the medication matches the prescription. The Nurse Supervisor will review the result of monthly medication audits. Performance will be reported to the Personal Care Administrator during Quality Management Program meetings.

The failure to obtain the pulse of Resident #3 appears to be an isolated incident involving one Medication Technician and one administration of digoxin. The Medication Technician has been educated to look for and comply with physician directions for obtaining vital signs with medication administration. By 3/29/2013, the Nurse Supervisor will review the importance of obtaining vital signs with medication administration when ordered by physicians with all Medication Technicians. Special instructions for medication administration have been highlighted to alert Medication Technicians.
The Nurse Supervisor and designees audits MARs each month to identify incidents of failure to follow physician prescription and provides individual and/or group re-education as needed. The Nurse Supervisor will report performance to the Personal Care Administrator during Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Dwayne Shower

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dwayne Shower's Personal Care Administrator — Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by FOW (Initials)

Plan of correction implementation status as of 6/7/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.223(b) - The home shall develop written procedures for the delivery and management of services from admission to discharge.

2a. DESCRIPTION OF VIOLATION
The home does not have written procedures for the delivery and management of services.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The policy on Delivery and Management of Services from Admission to Discharge provided a general overview of services offered by the home. Details on procedures for services were contained in separate policies and procedures for the services. Attached is the Table of Content for the Heritage Towers Personal Care Policy and Procedure Manual.

On 2/18/2013, the policy on Delivery and Management of Services from Admission to Discharge was revised to list each service provided by the Personal Care Home and includes details on the positions qualified to perform the service and the timeframes for completing each service. By 3/29/2013, Personal Care Staff will be educated on the content of the attached revised policy.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Shavers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Shavers Personal Care Administrator

Date 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- [X] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.224(a) - 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.

2a. DESCRIPTION OF VIOLATION
The pre-admission screening form for resident #2, admitted 11/30/12, does not include a determination that the home can meet the service needs of the resident.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The pre-admission screening form for Resident #2 has been amended to include a late entry indicating that the Home can meet the service needs of the resident.

Since July 2012, the current quality review procedure has been effective at verifying presence of the required admission documents on 100% of newly admitted residents. Going forward, the quality review process has been amended to include a review of each document to ensure that it is accurately completed, including answering all questions and obtaining required signatures. The Personal Care Administrator or designee will monitor the effectiveness of this process by reviewing the records of newly admitted residents and reporting performance in the Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Dwayne Stevens

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dwayne E. Stevens, Personal Care Administrator — **Date** 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

- Resident #1's most recent assessment dated 6/20/12 does not address the resident's special diet of ground with think liquids and no straws, the resident's use of TED stockings, and the resident's fall history.

- Resident #3's most recent assessment dated 3/30/12 does not address the resident's use of a foley catheter.

- Resident #6's most recent assessment dated 12/22/12 does not address the resident's wound care and the resident's fall history.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The RASP for Resident #1 was amended on 2/15/2013 to appropriately address the resident's special diet of ground with thick liquids and no straws, the resident's use of TED stockings, and the resident's fall history. The resident and Designated Other were notified about the amendment to the RASP.

The RASP for Resident #3 was amended on 2/15/2013 to appropriately address the resident's use of a foley catheter. The resident and Designated Other were notified about the amendment to the RASP.

The RASP for Resident #6 was amended on 2/15/2013 to appropriately address the resident's wound care needs and the resident's fall history. The resident and Designated Other were notified about the amendment to the RASP.

By 3/29/2013, the resident records and RASPs of 100% of current residents will be reviewed and amended as necessary so that the special diet, fall history, and special care needs are addressed on the RASP. The respective residents, Designated Persons, and the physicians will be notified of the amendment.

Going forward, when new physician orders are received or new/changing care needs are identified, the Nurse Supervisor or designee will flag the resident record for review by the Nurse Supervisor. The Nurse Supervisor or designee will amend the RASP within 5 days to ensure care needs are assessed and a support plan is developed. The Nurse Supervisor will review all flagged records to ensure RASPs are updated. Performance will be reported to the Personal Care Administrator during Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)				
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Danyelle Showers Personal Care Administrator			**Date** 3/14/2013	

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 - 02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600

2600.227(d) - Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.

2a. DESCRIPTION OF VIOLATION

- Resident #3's most recent support plan dated 4/4/12 does not address the assistance that the resident needs during emergency evacuations.

- Resident #6's most recent support plan dated 12/24/11 does not address the assistance that the resident needs during emergency evacuations.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Our quality review of Resident Assessment and Support Plans (RASP) included confirming the mobility status on the RASP matched the mobility status indicated by the physician on the DME, and the assessment and corresponding support plan documented on the RASP were reflective of the residents' needs as observed by Direct Care Staff.

The physician for Resident #3 indicated the mobility status of "Moderate (Immobile)". The assessment and corresponding support plan for Resident #3 reflects actual limited need for assistance to evacuate in an emergency, which is consistent will "Minimal (Mobile)". On 3/13/2013, the assessment and support plan were amended to indicate the Direct Care Staff's assessment level as "Minimal (Mobile)". The resident, Designated Person, and physician will be notified of the amendment.

The physician for Resident #6 indicated the mobility status of "Moderate (Immobile)". The assessment and corresponding support plan for Resident #6 reflects actual limited need for assistance to evacuate in an emergency, which is consistent will "Minimal (Mobile)". On 3/13/2013, the assessment and support plan were amended to indicate the Direct Care Staff's assessment level as "Minimal (Mobile)". The resident, Designated Person, and physician will be notified of the amendment.

By 3/29/2013, the mobility assessments and support plans of 100% of current residents will be reviewed and amended as necessary so that the mobility assessment level is reflective of the actual assessments and support plans developed by Direct Care Staff. The respective residents, Designated Persons, and the physicians will be notified of the amendment.

Going forward, mobility assistance assessment levels indicated on RASPs is reflective of the assessments and support plans developed by Direct Care Staff. If the mobility designation developed by the Direct Care Staff differs from the physician's mobility level designation, the physician will be contacted and a note will be entered into the resident's record. The Nurse Supervisor will review all new and annual RASPs, DMEs, and resident records to verify appropriate mobility level designations. Performance will be reported to the Personal Care Administrator during Quality Management Program meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Donyale Stowers

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Donyale Stowers, Personal Care Administrator — **Date** 3/14/2013

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 5/13/13 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 5/17/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 12718 -.02/14/2013 - McHale, Christine
PCH Name: HERITAGE TOWERS

1. REGULATION 55 Pa.Code §2600
2600.251(c) - The home shall use standardized forms to record information in the resident's record.

2a. DESCRIPTION OF VIOLATION
The home did not completed resident assessments and support plans, using the required forms, for residents #7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20 and 21.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The New Heritage Towers is a Continuing Care Retirement Community that has independent living apartments, a Personal Care Home (Heritage Towers), and a Skilled Nursing Facility. Residents # 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, and 20 are independent living residents being served by Wesley Enhanced Living Doylestown Home Care Agency (License #18563601), a home care agency which is separately licensed by the Pennsylvania Department of Health. Documents provided for home care agency clients comply with the regulations that govern home care agencies - Title 28 Part IV Subpart H Chapter 611. Assessments and support plans for each of these residents were developed and documented using home care agency standard forms. Home care regulations do not require home care agencies to utilize forms developed by DPW.

Heritage Towers is in disagreement with the violation because the cited residents live on upper floors and receive services under a PA DOH Home Care License, in cooperation with a plan to have all DPW licensed Personal Care services provided on floors 2 and 3 of the CCRC high-rise building. This arrangement had tacit and verbal approval by the local licensing office. A change in this approval came through a telephone call from the local office on (about) 3/1/2013 indicating that due to a new determination by DPW, additional violations would be added to those pertaining to the 2/14/2013-2/15/2013 survey, that would require consideration of persons served under the Home Care license would need to follow all DPW Personal Care rules and regulations. We believe dual licensure is unnecessary for wellbeing and appropriate serving clients and that the said division by floor is appropriate.

However, if the violation remains, the plan to correct is as follows: By 4/10/2013, the PC Administrator will prescreen Residents #7, 8, 9, 10, 11, 12, 13 14, 15, 16, 17, 18, 19, and 20 and present the appropriate residents with resident home contracts for becoming residents of Heritage Towers Personal Care Home. The PC Nurse Supervisor or designee will complete a resident assessment for each new admission within 15 days of admissions utilizing the required DPW form (RASP). Within 30 days of admission, the PC Nurse Supervisor or designee will complete an individualized support plan for each resident using the required DPW form (RASP). The PC nurse supervisor or designee will review the RASP form for each these newly admitted residents to ensure it is completed in adherence with our current procedure for completing assessment and support plan documentation for newly admitted residents,. The PC Nurse Supervisor will report findings in the Quality Management Program Meetings.

Resident #15 is a resident of the Heritage Towers Personal Care Home effective 2/11/2013, and has an assessment and support plan documented on the DPW RASP form. Resident #21 discontinued receiving services effective 1/16/2013.

Corrective action is not required.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page) Dongale Stevens

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Dongale Stevens Personal Care Administrator

Date 4/1/2013

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The above plan of correction is approved as of 5/1/13 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 6/7/13 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented