



pennsylvania
DEPARTMENT OF HUMAN SERVICES

AUG 04 2016

Mr. David Levitz, President HSC
GAHC3 Boyertown PA ALF TRS SUB LLC
18191 Von Karman Avenue, Suite 300
Irvine, California 91612

RE: Chestnut Knoll
120 West Fifth Street
Boyertown, Pennsylvania 19512
License #: 226130

Dear Mr. Levitz:

As a result of the Department of Human Services' annual licensing inspection on April 12, 2016 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jay Bausch".

Jay Bausch
Deputy Secretary

Enclosure
License Inspection Summary

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

| | | |
|--|-----------------------------|--|
| PCH Name: CHESTNUT KNOLL | | License Number: 22613 |
| Address: 120 WEST 5TH STREET, BOYERTOWN, PA 19512 | | County: Berks |
| Administrator: SHAWN BARNDT | | Region: NORTHEAST |
| Legal Entity Name: GAHC3 BOYERTOWN PA ALF TRS SUB, LLC | | |
| Legal Entity Address: 18191 VON KARMAN AVENUE, IRVINE, CA 92612 | | |
| Certificate(s) of Occupancy | | |
| I-2 08/16/2006 Borough of Boyertown | C-2 LP 08/21/2000 L&I | |
| Staffing Hours | | |
| Resident Support: 0 | Total Daily Staff: 159 | Waking Staff: 119 |
| Type of Inspection: Full | BHA Docket Number: | Notice: Unannounced |
| Reason(s) for Inspection(s) | | |
| Renewal | | |
| On-Site Inspections Dates and Department Representatives On-Site | | |
| 04/12/2016: Novak, Ryan; Dumas, Gerald | | |
| 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: 119 Number of Residents Served: 110 Secured Dementia Care Unit in Home: Yes Area: N/A Secured Dementia Unit Capacity, if Applicable: 52 Number of Residents Served in Secured Dementia Care Unit, if applicable: 46 Number of Current Hospice Residents: 13 Number of Hospice Residents in past year: 39 | | Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 110 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 49 Have a Physical Disability: 0 |

Violation Report: 22613 - 04/12/2016 - Novak, Ryan
 PCH Name: CHESTNUT KNOLL

1. REGULATION 55 Pa.Code §2600
 2600.107(c) - The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

2a. DESCRIPTION OF VIOLATION

The home did not have on hand a 3 day supply of non-perishable foods nor the did not have a letter to specifically indicate that food would be immediately provided in the event of an emergency. On the day of the inspection the home had a census 110 residents.

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.

Chestnut Knoll understands the importance of keeping a 3 day non perishable food supply on hand in case of emergency.
 In this instance, our non perishable supply had been rotated out prior to the new supply being received. The 3 day non perishable supply was received on 4/13/16 putting the facility back into compliance with this regulation. Furthermore, US Foods has made a commitment to provide additional emergency water as well as emergency food within 24 hours in case of emergency. (see attached supportive documentation)
 Moving forward, the Food Service Director will ensure a 3 day supply is maintained and not rotated out until the new / replacement supply has been received. The non perishable food supply is rotated out every 6 months in order to ensure that items do not expire and result in waste. A check of the non perishable food supply will be added to the facility dining QI quarterly audit in order to ensure ongoing compliance. It is the responsibility of the Food Service Director to complete the audit process and ensure compliance.

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *Shawn Barrett, Executive Director*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Shawn Barrett, Executive Dir.* Date *4/29/16*

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The above plan of correction is approved as of 6/25/16
 (Date)

Plan of correction implementation status as of 6/25/16
 (Date)

The above plan of correction was approved by

[Handwritten initials]
 (Initials)

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

Violation Report: 22613 - 04/12/2016 - Novak, Ryan

PCH Name: CHESTNUT KNOLL

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- (10) Duration of therapy, if applicable.
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION

Resident #2 is prescribed to have accuchecks conducted twice daily before breakfast and supper. The resident is also on a sliding scale. Readings on 4/9/16 at 4:30 p.m. indicated the resident's blood glucose was 270. The home did not document that the resident received 4 units of insulin. On 4/10/16 at 4:30 p.m., the resident's blood glucose indicated a reading of 373. The home did not document that the resident received 8 units of insulin. On 4/11/16 at 7:30 a.m., the resident's blood glucose reading indicated blood glucose of 263. The home did not document that the resident received 4 units of insulin.

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.

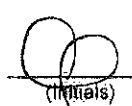
A representative from Quick Mar was contacted immediately and by the end of the day on 4/12/16 a new default setting was added to the EMAR in order to create a 'box' where the number of units are recorded on the EMAR for those residents who have an order for sliding scale insulin. The med techs were in serviced on the new 'box' and procedure to enter the actual amount of insulin administered. (see attached supporting documentation). Under the new procedure, after a resident's glucose level is checked, the amount of insulin as ordered by the MD is administered and then recorded into this new 'box' on the EMAR. When a new order is received, a member of the professional nursing team, double check that the box is present. The Director of resident services will ensure ongoing compliance through quarterly QI audits.

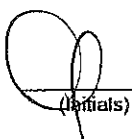
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| Repeat Violation: No | Date(s) of Previous Violation(s): | | |
|----------------------|-----------------------------------|--|--|

Signature of Legal Entity Representative
(Required on EVERY Page) *S. Barnhart, Executive Director*

| | |
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| Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Shawn Barnhart, Exec. Director</i> | Date <i>4/29/16</i> |
|---|---------------------|

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| The above plan of correction is approved as of <u>6/25/16</u> (Date) | Plan of correction implementation status as of <u>6/25/16</u> (Date) |
| The above plan of correction was approved by  (Initials) | <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented |

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|---|---|
| Violation Report: 22613 - 04/12/2016 - Novak, Ryan PCH Name: CHESTNUT KNOLL | |
| 1. REGULATION 55 Pa.Code §2600 2600.187(d) - The home shall follow the directions of the prescriber. | |
| 2a. DESCRIPTION OF VIOLATION Resident #1 has an order for enalapril 10mg tablet hold for systolic blood pressure less than or equal to 120. On 4/11/16 the blood pressure was 120/55 and the medication was administered. | |
| 3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) <i>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.</i> | |
| <p>This medication error was reported to BHSL via a reportable incident form, to the physician, the resident, and responsible party per CK reportable incident policy. There were no new orders or adverse effects from the BP medication being given.</p> <p>The med tech was coached on the importance of reading the orders closely as in this case she missed the 'equal to' sign and administered the medication in error.</p> <p>In this instance, the order was clarified with the MD who changed it to be take one tablet by mouth * hold for SBP less than 120 thus eliminating the confusion of the 'equal to' sign. (see attached supporting documentation)</p> <p>Going forward, the nurse accepting the MD order will read the order to look for anything that may cause confusion such as this and ask the MD for further clarification to avoid confusion.</p> <p>The Director of Resident care will ensure ongoing compliance through quarterly QI audits of the EMAR orders.</p> | |
| Repeat Violation: No | Date(s) of Previous Violation(s): |
| Signature of Legal Entity Representative (Required on EVERY Page) <i>S. Bennett, Executive Director</i> | |
| Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Shawn Bennett, Executive Director</i> | Date <i>4/25/16</i> |
| DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE! | |
| The above plan of correction is approved as of <u>6/25/16</u> (Date) | Plan of correction implementation status as of <u>6/25/16</u> (Date) |
| The above plan of correction was approved by  (Initials) | <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented |