pennsylvania
DEPARTMENT OF HUMAN SERVICES

FEB 0 3 2017

Ms. Kelly Andress, President
Berwyn Real Estate LP
1489 Baltimore Pike, Suite 245
Springfield, Pennsylvania 19064

RE: Daylesford Crossing
1450 East Lancaster Avenue
Paoli, Pennsylvania 19301
License #: 141540

Dear Ms. Andress:

As a result of the Department of Human Services' annual licensing inspections on September 7, 2016, September 8, 2016 and November 9, 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,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

#141540

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

PCH Name: Daylesford Crossing	License Number: 14164
Address: 1450 East Lancaster Avenue, Paoli, PA 19301	County: Chester
Administrator: Kristina Wilhelmsen	Region: CENTRAL

Legal Entity Name: Berwyn Real Estate LP

Legal Entity Address: 1489 Baltimore Pike, Suite 245, Springfield, PA 19301

Certificate(s) of Occupancy

I-2
08/05/2015
Tredyffrin Township

Staffing Hours

Resident Support: 0 | Total Daily Staff: 108 | Waking Staff: 81

Type of Inspection: Full | **BHA Docket Number:** | **Notice:** Unannounced

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

09/07/2016: McCloskey, Jason; Bomberger, Cybil
09/08/2016: McCloskey, Jason; Showers, Michael

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: 100

Number of Residents Served: 74

Secured Dementia Care Unit in Home: Yes

Area: Connections

Secured Dementia Unit Capacity, If Applicable: 24

Number of Residents Served in Secured Dementia Care Unit, If applicable: 19

Number of Current Hospice Residents: 7

Number of Hospice Residents in past year: 5

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 74

Have Mental Illness: 13

Have an Intellectual Disability: 0

Have a Mobility Need: 34

Have a Physical Disability: 0

#141540

Kristina M. Wilhelmsen Exec Dir

14154

Violation Report: 14154 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.16(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION

On 12-31-15, allegations of the theft of personal property belonging to Resident 2 were reported to the home. The home did not report the allegations of Financial Exploitation to the local Area Agency on Aging.

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.

2600.16(a)

What specific change will be made:
Administrator and department heads have been re-educated on the DHS requirements for mandatory reporting within 24 hours of an event. The administrator and department heads were re-educated on 9/23/16 by reviewing the Regulatory Compliance Guide with special emphasis placed on notifying a theft reportable to Area Agency on Aging and the PA Regional Office of DHS.

Who will make the change:
The administrator and/or department head will be responsible for reporting all reportable events including events, like theft, that result in emergency personnel response.

System implemented to make sure the same violation does not occur again:
Administrator and/or the Department heads will be contacted regarding all reportable events. The Administrator or the Department heads will make certain that the regional office is provided with a report on the approved reportable format and submit to the regional office within 24 hours. All department heads have been educated to report to administrator any reportable events. The administrator and department heads have reviewed the requirements for documentation and have been trained on the completion of the form and the method of transmission. All incidents are reviewed monthly as part of the quality safety program.

Supportive documentation:
Training record, Reportable incident and conditions Policy

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Williamson

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILLIAMSON PL. DIR

Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14154

Violation Report: 14154 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 12-31-15, an allegation of theft was reported to the local police department and an officer responded to the home. The home did not report the incident to the Department.

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.

2600.16(c)

What specific change will be made:
Administrator and department heads have been re-educated on the DHS requirements for mandatory reporting within 24 hours of an event. The administrator and department heads were re-educated on 9/23/16 by reviewing the Regulatory Compliance Guide with special emphasis placed on notifying a reportable to PA Regional Office.

Who will make the change:
The administrator and/or department head will be responsible for reporting all reportable events including events, like theft, that result in emergency personnel response.

System implemented to make sure the same violation does not occur again:
Administrator and/or the Department heads will be contacted regarding all reportable events. The Administrator or the Department heads will make certain that the regional office is provided with a report on the approved reportable format and submit to the regional office within 24 hours. All department heads have been educated to report to administrator any reportable events. The administrator and department heads have reviewed the requirements for documentation and have been trained on the completion of the form and the method of transmission. All incidents are reviewed monthly as part of the quality safety program.

Supportive documentation:
Training record, Reportable incident and conditions Policy

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Williamson

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILLIAMSON EXEC | **Date** 10/6/16

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The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14154C

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION
On 9-7-16, at 9:17am, medication administration records (MARs) were unlocked and accessible on top of an unattended medication cart in the hallway outside of resident bedrooms 222 and 223.

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.

2600.17

What specific change was made:
An In-service was conducted with LPN and Medication Technician staff to include regulation 55 PA. Code 2600.17 that Resident records shall be kept confidential. Staff were educated on resident rights to confidentiality and the regulation. An area was made available in the bottom of the cart for the MAR to be stored and locked.

Who will make the change:
The Director of Nursing has made the change. The In-service was conducted on 9/28/16.

System implemented to make sure the same violation does not occur again:
Reminder notice has been put on all MAR books to remind staff that the MAR book is to be placed in cabinet at bottom of cart when Med Technician is not with the cart.

Supportive documentation:
In-service training record, Picture of MAR book in its new location

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Willhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. Willhelmsen Ex. Dir | Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress

14156

Violation Report: 14156 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.51 - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults).

2a. DESCRIPTION OF VIOLATION
No criminal history background checks (CHBCs) were performed on the following staff:
- direct care staff person C, hired [redacted]15;
- direct care staff person D, hired [redacted]15;
- ancillary staff person E, hired [redacted]16.

A CHBC was performed for direct care staff person F, hired 12-7-15, however the background check was not conducted, as required, through the Pennsylvania State Police.

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.

2600.51

What specific change will be made:
Criminal Background checks via the PA State Police Epatch website were immediately performed on all direct care staff that were cited. All Background checks going forward will be made through the State Police. The recently hired Business Office Manager has been notified of the requirement as a condition of hire. The service company we were previously using, InfoCubic, will no longer be performing any background checks for our company.

Who will make the change:
The Business Office Manager

When the Change will be made:
The change went into effect immediately for all hired after 9/9/2016. All employee files will be audited (& SPOT CHECKED w/ monthly QA MEETING) TO assure that they are in compliance and have the State Police Criminal Background Check in their files.
All background checks will be completed by 10/15/16.

System implemented to make sure the same violation does not occur again:
Monthly employee file audits for compliance will be performed as part of our Quality Management Report.

Supportive documentation:
Criminal Background checks for Employees C, D, E, and F,
Email from InfoCubic indicating their background check procedure.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. McCloskey

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina W. Williams Ex. Dir. **Date** 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.54(a) - Direct care staff persons shall have the following qualifications:
(1) Be 18 years of age or older, except as permitted in § 2600.54(b).
(2) Have a high school diploma, GED diploma, 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 services with reasonable skill and safety.

2a. DESCRIPTION OF VIOLATION
Direct care staff person C does not have a high school diploma, GED or active status on the Pennsylvania nurse aide registry.

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.

2600.54(a)

What specific change will be made:
Direct care staff person did have an expired CNA license, years of experience in caregiving but did not have a high school diploma from this country. A request of waiver was sent in to BHSL.

Who will make the change:
The administrator sent in the request of waiver to BHSL on 9/18/16

System implemented to make sure the same violation does not occur again:
Business Office Manager has added the high school diploma requirement for all new hires in the direct caro department. If they provide a current registration on the Pennsylvania nurse aide registry they will be exempt from providing the diploma.

Supportive documentation:
Copy of Waiver Application, Policy, Copy of New Hire Requirements

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILHELMSEN Date 10/6/16

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

The above plan of correction is approved as of 10/17/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14540

Violation Report: 14760 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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 Tide Pods, with a manufacturer's label indicating "call poison control or physician" was unlocked and accessible to residents in the Connections laundry room. Residents of the Connections secure dementia care unit are not assessed to be 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.

2600.82(c)

What specific change will be made:
- Staff was in-serviced on importance of locking up poisonous materials.
- Locked cabinet is being used in Laundry Room to secure all cleaning supplies.

Who will make the change:
The Director of Nursing

When the Change will be made:
The change went into effect immediately.

System implemented to make sure the same violation does not occur again:
- In-service all staff on poisons
- Key to remove Laundry Room poisons from the locked cabinet must be signed out with either the Director or the Medication Technician.

Need pic of locked cabinet

Supportive documentation:
In-service Training Sheet
Picture of Locked Cabinet

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Kristina W. Wilhelmsen			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	KRISTINA W. WILHELMSEN EX DIR		**Date**	10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

BAS

Plan of correction implementation status as of 11/9/16 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress

14154D

Violation Report: 14350 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.91 - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

2a. DESCRIPTION OF VIOLATION
The telephones in bedrooms 310 and 115a do not have emergency service numbers posted nearby.

The emergency service numbers posted in bedroom 324 do not include the correct telephone number for the personal care home complaint hotline.

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.

2600.91

What specific change was made:
- New Stickers were made that had the correct phone number listing for the Personal care home complaint hotline.
- A new sticker was placed near the phone in every resident apartment, including apartments 310 and 115A, and on all common area phones.

Who will make the change:
The Facilities Director

When the Change will be made:
The change went into effect immediately.

System Implemented to make sure the same violation does not occur again:
- The Facility Director will make sure that all phones have a sticker prior to new resident move in.
- The residents will be directed at the next resident council meeting that the stickers are not to be removed from the phone.

Supportive documentation:
Copy of the stickers
Picture of a phone with new sticker

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilkelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILKELMSEN EX DIR

Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

The above plan of correction was approved by BAS

Plan of correction implementation status as of 10/13/16 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress

14154O

Violation Report: 14160 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.100(a) - The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION
A door to the roof was unlocked and allowed anyone, including residents, staff and visitors, access to the rooftop. There is no railing or other barrier preventing someone from falling from the rooftop.

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.

2600.100(a)

What specific change was made:
The door to the roof has been locked which will prevent any resident, staff or visitor from accessing the rooftop.

Who made the change:
The Building Engineer

When the Change was made:
The door was locked on 9/7/16, during the inspection.

System Implemented to make sure the same violation does not occur again:
Building Engineer will check the door daily.

Supportive documentation:
- Picture of the locked door

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina M. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina M. Wilhelmsen — Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

Violation Report: 141540 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION
The last drill conducted during sleeping hours was on 5-25-16. The home did not conduct any sleeping hours drills in the 8 months prior to 5-25-16.

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.

2600.132(e)

What specific change was made:
A 6am fire drill was performed on 9/29/16.

Who made the change:
The Building Engineer

When the Change was made:
The fire drill was performed on 9/29/16.

System implemented to make sure the same violation does not occur again:
A schedule of future fire drills has been developed to include 3 night drills between the hours of 11pm and 7am.

Supportive documentation:
- Fire Drill information from 9/29/16
- Schedule of future fire drill days and times

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen EX. DR

Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

The above plan of correction was approved by RAS

Plan of correction implementation status as of 10/13/16 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
Resident 3's most recent medical evaluation was completed on 8-15-16. The previous medical evaluation was completed on 7-13-15..

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.

2600.141(b)(1)

What specific change was made:
- A letter that will be sent to all residents 60 days prior to their admittance date that will advise them that their medical examination is due.
- A calendar will act as a 2nd reminder to the Director of Nursing.

Who made the change:
The Director of Nursing

When the Change was made:
The change was made Immediately on 9/9/2016.

System Implemented to make sure the same violation does not occur again:
A letter will go out to all residents prior to the residents' move in date to remind them to get their medical exam. The resident name will be put on a DME due date calendar that will indicate when each resident DME is due.

Supportive documentation:
- Copy of letter to be sent out to resident regarding annual medical examination
- Picture of calendar that is in Director of Nursing office.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristine W. Welsh

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristine W. Williamsen — Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

The above plan of correction was approved by BAS

Plan of correction implementation status as of 11/9/16 (Date)

- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.144(c) - A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include 2600.144(c)1-3.

2a. DESCRIPTION OF VIOLATION
The home permits smoking at a designated area in the back parking lot. At approximately 3:45pm on 9-7-16, a licensing representative saw a staff person sitting on the east sidewalk immediately adjacent to the building smoking a cigarette. The licensing representative counted 10 cigarette butts in the immediate area where the staff person was smoking.

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

cannot be completed

2600.144(c) Please review this violation of regulation as I think we were in compliance of the regulation by providing and maintaining a designated smoking area.

Daylesford Crossing has a designated smoking area in the rear of parking lot. There is a bench and a fireproof receptacle and ashtray. The employees are notified of the area in their handbooks upon hire.

At time of inspection, an employee was smoking at the area near our loading dock. Per [redacted] the employee was aware of where the designated smoking area was located and chose not to go to the area. The cigarette butts in the area were most likely from delivery truck drivers. .

What specific change was made:

- A no smoking sign has been installed at loading dock area.
- A sign to remind employees about where the designated smoking area is located was posted near the rear exit of the building.

Who made the change:
The Administrator

When the Change was made:
The change was made on 9/30/16.

System Implemented to make sure the same violation does not occur again:

- Signs were posted.
- Employees will be reminded of smoking area at the next employee meeting on 10/7/16.

Supportive documentation:

- Pictures of Signs

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

Signature of Legal Entity Representative (Required on EVERY Page) Krista W. Wilhelm

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Krista W. Wilhelm | **Date** 10/4/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 10/13/16 (Date)

- [x] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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 9/8/16, the following medications were located in the home's medication cart:
- Resident 4's ***Levemir Flextouch Insulin pen*** was opened 6-26-16. The manufacturer's label states to discard opened, unrefrigerated doses within 42 days.

- Resident 4's ***Humalog Kwik Pen*** was opened 7-18-16. The manufacturer's label states to throw away unused doses after 28 days.

- Resident 5's ***Milk of Magnesia*** has a manufacturer's label indicating it expired 4/16.

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.

2600.183(d)

What specific change will be made:
- The insulin pens were immediately discarded
- The Milk of Magnesia was immediately discarded
- The Source One Pharmacy was called in and performed an audit
- New insulin pens were dated and put into med cart.
- New Insulin record sheets were implemented
- In-service to changes will be performed on 10/7/16

Who will make the change:
Director of Nursing

When will the change be made:
Immediately for all except LPN in-service will be on 10/7/16

System implemented to make sure the same violation does not occur again:
Audit checks are performed two times per week by the LPN.

Supportive documentation:
Med Cart Audit Checklist, Insulin recording sheet, inservice sheet.

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILHELMSEN — **Date** 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14154D

Violation Report: 14160 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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
The medication administration records (MARs) for the Connections secure dementia care unit do not include the full printed names of staff who administer medications.

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

If be completed

li
li

2600.187(a)

What specific change will be made:
A master medication administration record with the full names of the staff who administer the medications will be kept with the MAR. The record that was being used in the rest of the building was completed and added to the Connections MAR.

Who will make the change:
Director of Nursing

When will the change be made:
Immediately

System implemented to make sure the same violation does not occur again:
Signature sheet will be located inside every MAR in building.

Supportive documentation:
Copy of the Master Medication Administration Signature Sheet

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilh

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. Wilhelmsen — **Date** 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14154D

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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

2a. DESCRIPTION OF VIOLATION
Resident 4's ***Humalog Kwik Inj Pen 100/ml - 5 units subcutaneously*** was not administered on 9-4 or 9-5-16 at 4:30pm or on 9-7-16 at 9:00am.

Resident 4's ***Levemir Flextouch INJ*** was not administered on 9-6-16 at 9:00pm.

Resident 4's blood sugar was not checked on 9-5-16 at 9:00 pm, as directed on the resident's Medication Administration Record.

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.

2600.187(d)

What specific change will be made:
An addendum to the MAR was typed to clarify orders and to make it easier to record and read blood sugars and insulin administered addendum was implemented.

Who will make the change:
Director of Nursing

When will the change be made:
The addendum will be implemented immediately. The LPN's will be inserviced on 10/7/16 immediately following the monthly employee meeting

System implemented to make sure the same violation does not occur again:
The new addendum will checked two times per week along with the med cart audit.

Supportive documentation:
Insulin record log, Addendum to MAR, In-service Records

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristin W. Wilhelm

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristin W. Wilhelm — **Date** 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress

14150

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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 6 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.

2600.224(a)

What specific change will be made:
The Admission checklist was revised to require two signatures verifying that the preadmission screening form is complete.

Who will make the change:
Director of Nursing

When will the change be made:
Immediately

System implemented to make sure the same violation does not occur again:
The two person check will prevent a preadmission screening from having any blank or unchecked boxes.

Supportive documentation:
Admission Checklist

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristen W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristen W. Wilhelmsen, ED. **Date** 12/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress

Violation Report: 14160 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600
2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
Resident 7, a resident of the home's Secured Dementia Care Unit (SDCU), had a medical evaluation completed on 4-22-2016. This evaluation did not document the resident's need for placement into the SDCU.

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.

2600.231(b)

What specific change will be made:
The Admission checklist was revised to require two signatures verifying that all sections of the DME are complete.

Who will make the change:
Director of Nursing

When will the change be made:
Immediately

System implemented to make sure the same violation does not occur again:
The two person check will prevent a DME from having any blank or unchecked boxes.

Supportive documentation:
Admission Checklist

The administrator, and/or designee, will complete an audit of the most recent DMEs for the residents of the SDCU to assure that each resident has a continuing need for the SDCU placement. For those DMEs found not to have this need designated, contact will be made with the physician to obtain a written statement to identify that this need exists. BAS 10/13/16

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristia W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen **Date** 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

14150

Violation Report: 14150 - 09/07/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600

2600.233(c) - If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

2a. DESCRIPTION OF VIOLATION

The directions the home posted for operating the locking mechanisms for the gate located in the courtyard of the Secured Dementia Care Unit and the interior exit door adjacent to bedroom 14 did not provide conspicuous instructions for their use.

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.

2600.233(c)

What specific change was made:
A sign with the key code for opening gate was conspicuously placed near the key pad.

Who made the change:
The Administrator

When the Change was made:
9/8/16

System implemented to make sure the same violation does not occur again:
A permanent sign has been placed near the gate and inside the door that leads to the courtyard area.

Supportive documentation:

- Pictures of Signs

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Williams

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina W. Williams

Date 10/6/16

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

The above plan of correction is approved as of 10/13/16 (Date)

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

Plan of correction implementation status as of 11/9/16 (Date)

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

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

PCH Name: Dayleaford Crossing	License Number: 14154
Address: 1450 East Lancaster Avenue, Paoli, PA 19301	County: Chester
Administrator: Kristina Wilhelmsen	Region: CENTRAL
Legal Entity Name: Berwyn Real Estate LP	
Legal Entity Address: 1489 Baltimore Pike, Springfield, PA 19301	

Certificate(s) of Occupancy
I-2
08/05/2016
Tredyffrin Township

Staffing Hours

Resident Support: 0	Total Daily Staff: 117	Waking Staff: 88
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Interim, Complaint

On-Site Inspections Dates and Department Representatives On-Site
11/09/2016: McCloskey, Jason; Gillespie, Denise

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: 100	Number of Residents who:
Number of Residents Served: 81	Receive Supplemental Security Income: 0
Secured Dementia Care Unit In Home: Yes	Are 60 Years of Age or Older: 81
Area: Connections	Have Mental Illness: 13
Secured Dementia Unit Capacity, If Applicable: 24	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable: 18	Have a Mobility Need: 36
Number of Current Hospice Residents: 6	Have a Physical Disability: 0
Number of Hospice Residents in past year: 13	

Kristina W. Wilhelmsen, ED
12/1/16

Violation Report: 14154 - 11/09/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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.

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.

2600.25(b)

Situation:
The Resident Contract was signed by the Secured Dementia Unit Resident's POA and not by the SDU Resident.

What specific change will be made:
The Marketing Department Manager and the Business Office Manager have been instructed to have every resident at least attempt to sign every Resident Contract.

Who will make the change:
The Business Office Manager will insure that all Contracts are signed properly before being filed.

When the Change will be made:
The Resident Contract for Resident 1 has been signed and dated. All other Resident Contracts will be audited for incomplete signatures by 12/31/16.

System implemented to make sure the same violation does not occur again:
Monthly Resident Contract audits for compliance will be performed as part of our Quality Management Report meeting.

Supportive documentation:
Copy of Resident 1's Resident Contract signature page. "A"

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wolf Elmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WOLF ELMSEN, ED

Date 12/1/16

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

The above plan of correction is approved as of 12/5/16 (Date)

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

Plan of correction implementation status as of 12/5/16 (Date)

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

Violation Report: 14164 - 11/09/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600,
2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION
The medication administration record for resident 2 does not include the units of ***Humalog Insulin*** administered on 11-3-16, 11-6-16, 11-7-16, or 11-8-16.

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.

2600.187§(b)

Situation:
The medication administrative record for Resident 2 was incomplete.

What specific change will be made:
An Insulin and Blood sugar Addendum log sheet was created for the MAR for Resident 2.

Who will make the change:
The Director of Nursing created the new log sheet.

When the Change will be made:
The change has already been implemented. See copy of new log.

System implemented to make sure the same violation does not occur again:
Medication Technicians and Nurses administering insulin and checking blood glucose levels have all been informed of the new policy for recording levels and insulin given for all residents.

Supportive documentation:
Sample of Log Sheet that records Insulin and Blood Sugars. "B"

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristine W. Wilhelmsen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelmsen, ED. **Date** 12/1/16

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

The above plan of correction is approved as of 12/5/16 (Date)

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

Plan of correction implementation status as of 12/5/16 (Date)

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

Violation Report: 14154 - 11/09/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

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
The assessment for Resident 1, dated 6-16-16, was not completed in full. The areas designated for "Securing health care", "Securing and using transportation", and "Medication Administration" were left blank. In addition, the area assessed for "Supervision" is marked as "moderate" while the plan to meet supervision needs indicates that the resident requires 24 hour direct supervision.

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.

2600.225(c)

Situation:
While the data in the care plan reflected the needs of Resident 1, the small assessment boxes were erroneously left blank.

What specific change will be made:
Extra training will be given to all staff members to ensure that the boxes are not missed when entering the data into the electronic charting software. Also, it will always be noted that anyone in the Secured Dementia Unit will require total direct supervision.

Who will make the change:
The Director of Nursing will review all careplans for completeness.

When the Change will be made:
The change was made immediately.

Supportive documentation:
Copy of working RASP for Resident 1. "C"

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wellen

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WELLENSIEK, ED **Date** 12/1/16

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

The above plan of correction is approved as of 12/5/16 (Date)

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

Plan of correction implementation status as of 12/5/16 (Date)

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

Violation Report: 14154 - 11/09/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600.
2600.231(e) - Each resident record shall have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
Resident 1 was admitted to the Secure Dementia Care Unit of the home on [redacted]15. The resident did not sign a statement indicating that the resident does not object to the admission.

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.

2600.231e

Situation:
Resident 1 did not sign a statement indicating that [redacted] did not object to the admission into the Secured Dementia Unit. [redacted]son, The POA, signed the document. When Resident 1 moved into our community, [redacted]DME showed that [redacted] had approval of [redacted] Doctor to reside in the SDU.

What specific change will be made:
The Marketing Department Manager and the Business Office Manager have been instructed to have every SDU resident sign every SDU consent form which is attached as an addendum to the Personal Care residency agreement.

Who will make the change:
The Business Office Manager will insure that all Contracts are signed properly before being filed.

When the Change will be made:
The Consent for Admission for Resident 1 has been signed and dated. All other Resident Contracts will be audited for incomplete signatures by 12/31/16.

System implemented to make sure the same violation does not occur again:
Monthly Resident Contract audits for compliance will be performed as part of our Quality Management Report meeting.

Supportive documentation:
Copy of Resident 1's Resident Contract. Consent Form "D"

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina W. Wilhelm

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. Wilhelm — **Date** 12/1/16

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

The above plan of correction is approved as of 12/5/16 (Date)

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

Plan of correction implementation status as of 12/5/16 (Date)

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

Violation Report: 14154 - 11/09/2016 - McCloskey, Jason
PCH Name: Daylesford Crossing

1. REGULATION 55 Pa.Code §2600.
2600.234(d) - The support plan shall be revised at least annually and as the resident's condition changes.

2a. DESCRIPTION OF VIOLATION
The last support plan for Resident 1 was completed on 6-15-16. Since 8-2-16, the resident has presented multiple medication and treatment refusals, refusals to get out of bed, and refusals to eat any meals outside the resident's bedroom. The resident was transferred to a psychiatric hospital for treatment from 10-18-16 through 10-25-16. The resident's support plan has not been updated to address these behaviors. The support plan dated 6-15-16 states that the resident has no problems with Irritability, Judgement, and Aggression, and on Page 11 under the heading "Summary and Determination" states that the Resident is "very cooperative with care and medication."

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.

2600.234d

Situation: The last formal Care Plan Meeting was completed on 6/15/16 and the subsequent *signed* support plan from that meeting for Resident 1 was what was reviewed in the Resident's chart on the day of the investigation. The latest changes to Resident's support plan since that time (including a hospitalization in October) were not observed in the signed support plan in the Resident's chart.

What specific change will be made:
Our RASP is a working document that is constantly being updated in our e-charting system. The RASP was updated when Resident returned from the Hospital on 10/26/16. The reflections of his behaviors were updated but were not printed as part of the investigation. Even though there is not a signature with this working document, the RASP will be printed at "real time" to show the most current assessments.

Who will make the change:
The Director of Nursing and Executive Director will always print out the current e-file with the latest assessments and care plan.

When the Change will be made:
Immediately

Supportive documentation: Copy of current RASP "C"

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

Signature of Legal Entity Representative (Required on EVERY Page) Kristina Williams

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KRISTINA W. WILLIAMS, | **Date** 12/1/16

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

The above plan of correction is approved as of 12/5/16 (Date)

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

Plan of correction implementation status as of 12/5/16 (Date)

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