



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [REDACTED]

Mailing Date: January 10, 2017

Mr. Kevin Cysyk, Executive Director
GAHC3 York PA ALF TRS SUB, LLC
18191 Von Karman Avenue Suite 300
Irvine, California 92612

RE: Senior Commons at Powder Mill
1775 Powder Mill Road
York, Pennsylvania 17403
License #: 332101

Dear Mr. Cysyk:

As a result of the Department of Human Services' licensing inspection on November 23, 2016 and December 28, 2016 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, appearing to read "Brett Swanger".

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

PCH Name: Senior Commons at Powder Mill		License Number: 33210
Address: 1775 Powder Mill Road, York, PA 17403		County: York
Administrator: Jeremy Kelter		Region: CENTRAL
Legal Entity Name: GAHC3 York PA ALF TRS SUB LLC		
Legal Entity Address: 18191 Von Karman Avenue, Irvine, CA 92612		
Certificate(s) of Occupancy C-2 LP 07/23/2001 Labor and Industry		
Staffing Hours Resident Support: 0 Total Daily Staff: 140 Waking Staff: 105		
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Fine		
On-Site Inspections Dates and Department Representatives On-Site 11/23/2016: Gillespie, Denise; Springs, Israel		
Off-Site Inspection Dates and Inspectors, if Applicable		
Other Details Partial or Full Triggers: N/A Random Indicators: N/A		
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 166 Number of Residents Served: 112 Secured Dementia Care Unit in Home: Yes Area: Rosewood and Arlington Courts Secured Dementia Unit Capacity, if Applicable: 28 Number of Residents Served in Secured Dementia Care Unit, if applicable: 19 Number of Current Hospice Residents: 4 Number of Hospice Residents in past year: 14	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 112 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 28 Have a Physical Disability: 0	

Kai GR Kevin Cysuk EXECUTIVE DIRECTOR 12/7/16

Violation Report: 33210 - 11/23/2016 - Gillespie, Denise
 PCH Name: Senior Commons at Powder Mill

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 notes documented on the medication administration record for Resident #1 state that the prescribed Clonazepam 0.5 mg was not available for administration for the 10/25/16 bedtime dose and 10/26/16 morning dose. However, the medication administration record for Resident # 1 was initialed to signify that the medication was administered on these dates and times.

The medication administration record for Resident # 2 has the following medications recorded as administered on the following dates:

- 1. Digox 0.5 mg on 10/30/16, Morning Dose
- 2. Dorzol/Timolol 22.3-6.8 on 10/28/16, Bedtime Dose
- 3. Fluticasone SPR 50 mcg on 10/29/16 and 10/30/16, Morning Doses

These medications were not available for administration on these dates and times.

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.

PLEASE SEE ATTACHED 2a

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/07/2016
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Signature of Legal Entity Representative (Required on EVERY Page) *Kelvin Cusyk*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KELVIN CUSYK EXECUTIVE DIRECTOR Date 12/7/16

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

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

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

Plan of correction implementation status as of 12/28/16 (Date)

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

Plan of Correction
Senior Commons at Powder Mill
License Number: 33210
December 6, 2016

Description of Violation:
2600.187(a)

The notes documented on the medication administration record for Resident #1 state that the prescribed Clonazepam 0.5mg was not available for administration for the 10/25/16 bedtime dose and 10/26/16 morning dose. However, the medication administration record for Resident #1 was initialed to signify that the medication was administered on these dates and times.

The medication administration record for Resident #2 has the following medications recorded as administered on the following dates:

1. Digox 0.5mg on 10/30/16 morning dose
2. Dorzol/Timlol 22.3-6.8 on 10/28/16 bedtime dose
3. Fluticasone SPR 50mcg on 10/29/16 and 10/30/16, morning doses

These medications were not available for administration on these dates and times.

Repair of the immediate problem:

All current medications for Resident #1 and #2 have been obtained and are available for administration.

Root Cause:

While using the Electronic Administration Record, the Med Tech incorrectly documented the fact that the medication was not available to give. Rather than correctly marking in the Medication Administration Record, the Med Tech made a notation stating that the medication was "not here to give, waiting for Trinity <pharmacy> to deliver."

Steps to prevent future occurrence:

All persons responsible for medication administration will complete additional training regarding the appropriate actions that must be taken in the eMAR system to account for medications that were not administered due to not being available. Staff shifts were increased by ½ hour to allow time to review medication exceptions, possible missed medications, contact pharmacy for refills as necessary, and to enhance communication between shifts.

Person Responsible & Date of Correction:

██████████ LPN, Director of Resident Services conducted training on 12/5/16. Staff shifts were extended effective 12/1/16.

KEVIN CUSICK
EXECUTIVE DIRECTOR

12/7/16

Violation Report: 33210 - 11/23/2016 - Gillespie, Denise

PCH Name: Senior Commons at Powder Mill

1. REGULATION 55 Pa.Code §2600

2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #1 was not administered the prescribed Clonazepam 0.5 mg on 10/25/16 (bedtime dose) and 10/26/16 (morning dose), because the medication was not present in the home for administration.

Resident # 2 was not administered the following medications:

1. Digox 0.5 mg on 10/30/16, Morning Dose
2. Dorzol/Timolol 22.3-6.8 on 10/28/16, Bedtime Dose
3. Fluticasone SPR 50 mcg on 10/29/16 and 10/30/16, Morning Doses

These medications were not present in the home for administration on these dates and times.

On 11/6/16, Resident # 3 was not administered the prescribed afternoon dose of Acetamin 500 mg because the medication was not present in the home for administration.

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.

PLEASE SEE ATTACHED 3a

-The home will conduct daily MARs audits for all residents to identify and address any problems related to the ordering and availability of prescribed medications.

-The home will review the procedures for obtaining medications during the Quality Management Meetings to evaluate the efficacy of remedies put in place.

BAS 12/12/16

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/27/2016	06/07/2016	12/29/2015
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Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KEVIN CYSYK EXECUTIVE DIRECTOR Date 12/12/16

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

Plan of Correction
Senior Commons at Powder Mill
License Number: 33210
December 6, 2016

Description of Violation:

2600.187(d)

Resident #1 was not administered the prescribed Clonazepam 0.5mg on 10/25/16 (bedtime dose) and 10/26/16 (morning dose), because the medication was not present in the home for administration.

Resident #2 was not administered the following medications:

1. Digox 0.5mg on 10/30/16 morning dose
2. Dorzol/Timlol 22.3-6.8 on 10/28/16 bedtime dose
3. Fluticasone SPR 50mcg on 10/29/16 and 10/30/16, morning doses

These medications were not available for administration on these dates and times.

On 11/6/16, Resident #3 was not administered the prescribed afternoon dose of Acetamin 500 mg because the medication was not present in the home for administration.

Repair of the immediate problem:

All current medications for Resident #1, #2 and #3 have been obtained and are available for administration.

Root Cause:

Regarding Resident #1, the Clonazepam was not available for administration due to difficulty obtaining a hard copy of the prescription from the prescribing physician.

Resident #2 was a new admission and the family had communicated that they would be bringing medications upon move in but did not do so.

The Medication Administration Record for Resident #3 was marked as "held due to parameters." Though the medication was available, the dose in question was not administered due to the time of the morning medications. The morning medications were delivered late in the window, which would have been too close for this midday dose to be administered.

Steps to prevent future occurrence:

All persons responsible for medication administration will complete additional training regarding the appropriate actions that must be taken when medications are running low or not available, as in the case of a new resident. All persons responsible for medication administration have been instructed to secure medications from the pharmacy for any new admission that does not have medications at the time of arrival. Staff shifts were increased by 1/2 hour to allow time to review medication exceptions, possible missed medications, contact pharmacy for refills as necessary, and to enhance communication between shifts.

Person Responsible & Date of Correction:

[Redacted] LPN, Director of Resident Services conducted training on 12/5/16. Staff shifts were extended effective 12/1/16.

Kari Jon

*Karin Cusyk
Executive Director*

12/7/16