CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **1680 SPRING CREEK ROAD OPERATIONS LLC**
LEGAL ENTITY

To operate **LEHIGH COMMONS**
NAME OF FACILITY OR AGENCY

Located at **1680 SPRING CREEK ROAD, MACUNGIE, PA 18062**
(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

PROVISIONAL

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 **80**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 14**

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 **August 7, 2017** until **February 7, 2018**, unless sooner revoked for non-compliance with applicable laws and regulations.

No: **222051**

Robert E. Robinson
ISSUING OFFICER

Jay Bauch
DEPUTY SECRETARY

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

HS 628 – 12/14

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: AUG 0 8 2017

Mr. Marc Heil,
Executive Director
1680 Spring Creek Road Operations LLC
1680 Spring Creek Road
Macungie, Pennsylvania 18062

RE: Lehigh Commons
License #: 222051

Dear Mr. Heil:

As a result of the Department of Human Services' (Department) licensing inspections on April 19, 2017, May 24, 2017 and June 28, 2017 of the above facility, the violations specified on the enclosed Licensing Inspection Summary were found.

Based on violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes), your current license #222050 dated June 14, 2017 to June 14, 2018 is REVOKED. A FIRST PROVISIONAL license is being issued based on your plan to correct the violations as specified on the Licensing Inspection Summary. This first provisional license replaces all previously issued licenses and is effective for six months from the date of issuance. The license dated June 14, 2017 to June 14, 2018 is NOT reinstated upon expiration of this first provisional license. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your first provisional license is enclosed.

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

Pursuant to 62 P.S. 1085-1087 and 55 Pa.Code §§ 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violations unless fully corrected on or before the mandated correction date.

55 Pa.Code Chapter 2600 Section no.	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
60a	II	65	$5	$325	5 calendar days from mailing date of this letter
15a	III	65	$3	$195	15 calendar days from mailing date of this letter
227d	III	65	$3	$195	15 calendar days from mailing date of this letter

A fine will be assessed on a daily basis beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a provisional license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa.Code Part II, Chs. 31-35. If you decide to appeal your provisional license, a written request for an appeal must be received within 10 days of the date of this letter by:

Kevin Brumbach, Enforcement Manager
Bureau of Human Services Licensing
Department of Human Services
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Jacqueline L. Rowe
Director

Enclosures
License
Licensing Inspection Summary

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

PCH Name: LEHIGH COMMONS	License Number: 22205
Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062	County: Lehigh
Administrator: Thomas Howanitz	Region: NORTHEAST

Legal Entity Name: 1680 SPRING CREEK ROAD OPERATIONS LLC

Legal Entity Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062

Certificate(s) of Occupancy

C-2 LP
10/09/1997
PA Dept of L&I

Staffing Hours

Resident Support: 0 | Total Daily Staff: 79 | Waking Staff: 59

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

Reason(s) for Inspection(s)

Renewal, Complaint

On-Site Inspections Dates and Department Representatives On-Site

04/19/2017: Foulkes, Kimberli; Hummel, Jesse; Deluca, Amy

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: 80

Number of Residents Served: 60

Secured Dementia Care Unit in Home: Yes

Area: Homestead first floor wing

Secured Dementia Unit Capacity, if Applicable: 14

Number of Residents Served in Secured Dementia Care Unit, if applicable: 13

Number of Current Hospice Residents: 2

Number of Hospice Residents in past year: 2

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 60

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 19

Have a Physical Disability: 1

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600

2600.5(a)(1) - The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to: Agents of the Department.

2a. DESCRIPTION OF VIOLATION

Department Representatives requested the direct care staffing schedule as well as direct care staffing records at 10:00am. It was determined that these items are kept on-site at the facility. These items were subsequently requested at 10:45am and 11:30am. The facility provided the staffing schedule at 11:55am. Department Representatives obtained the staff records at 12:00pm. The facility is required to provide immediate access to records.

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.

Employee files will be reorganized in a manner that will allow immediate access to training, education and background information. Target date of completion, Sept 1st, 2017. Ongoing compliance will be monitored by the Business Office Manager or designee going forward.

The administrator shall monitor and assure ongoing compliance.

m 5/18/17

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) Thomas Horowitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.15(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 4/11/17 resident #1 reported to staff person A that staff person B was giving the resident a shower and that staff person B was rough and left a black and blue mark on the resident's right wrist. The home did not report the allegation to the local area agency on aging or the State Department of 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.

Allegation of abuse was reported on May 12th, 2017, a copy of Act-13 report attached. An in-service with all center staff will be completed on Abuse prohibition by June 2nd, 2017. Ongoing compliance will be monitored by the Executive Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
[signature] 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/28/2016		

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Howarth [illegible] | **Date** 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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
During the overnight hours on 2/10/17 into 2/11/17, resident #2 developed diarrhea. On 2/11/17 when staff checked on the resident at approximately 2:45pm, the resident was wheezing and stated they felt "lousy" and they had a temperature of 99.8 degrees Fahrenheit. The resident was admitted to Lehigh Valley Hospital with a dx of Sepsis and Pneumonia. The resident was discharged from the hospital to Lehigh Center on [redacted]17, was discharged from Lehigh Center back to Lehigh Valley Hospital on [redacted]17 and then expired at the hospital on [redacted]17. The home continued to hold the resident's bed and planned to have the resident return to the facility. As of the date of the inspection the resident's belongings were still in the home. The home has not submitted an incident report to the Department.

Resident #3 is prescribed Lidocaine 5% patch, one patch to skin daily, remove and discard patch within 12 hours, 6am and 6pm. The resident had not received the medication from 4/8/17 through 4/19/17. The resident is also prescribed Lovastatin 20mg, one tablet by mouth daily at 9pm. This medication was not administered from 4/8/17 through 4/14/17. The home has not submitted an incident report to the Department.

On 4/11/17 resident #1 reported to staff person A that staff person B was giving the resident a shower and that staff person B was rough and left a black and blue mark on the resident's right wrist. The home has not submitted an incident report 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.

An incident report, regarding the expiration of resident #2 was submitted on April 19th, 2017, copy attached. An Incident Report for resident #3 was submitted on May 12th, 2017, copy attached. All staff administering medication was in-serviced on May 3rd, 2017 on the necessity of medication being available as ordered by the physician. An Incident Report for resident #1 was submitted on May 12th, 2017, copy attached. The incident was also reported to the Area agency on aging on May 12th, 2017, copy attached. Ongoing compliance will be monitored by the Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance mr 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	10/28/2016		

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Herwarth(?) — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.18 - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

2a. DESCRIPTION OF VIOLATION
The facility has an industrial sized natural gas clothing dryer located in the basement of the facility and a natural gas fired oven located in the kitchen of the facility. The facility does have a carbon monoxide detector installed in each of these areas, however each detector is installed closer than 15 feet from each device. The facility is not in compliance with the Care Facility Carbon Monoxide Alarms Standards Act.

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.

All of the carbon monoxide alarms were relocated to be further than 15 feet away from each device on April 24th, 2017. Ongoing compliance will be monitored by the Director of Maintenance or designee going forward.

The administrator shall monitor and assure ongoing compliance.

5/18/17

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) Thomas Horwitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.26(a) - The home shall establish and implement a quality management plan.

2a. DESCRIPTION OF VIOLATION
The Quality Management Plan states meetings are to be held "10 times annually, preferably monthly". Minutes were recorded for meetings on 1/27, 2/24, 3/15, 5/18, 6/21, 11/17, and 12/28. Only 7 meetings were held in 2016.

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.

Quality Management meeting dates were established for 2017. A copy of the meeting schedule is attached. Compliance will be monitored by the Executive Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
5/18/17

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) Thomas Howanitz

Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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
Hospice employee C has a criminal history as indicated on his/her Pennsylvania State Police background check. The home did not obtain information about the details of the criminal 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.

Information regarding the criminal history of Employee "C" was obtained on May 10th, 2017. Copy of Pennsylvania State Police report is attached. All vendors will be advised that a criminal background check must be provided prior to providing services to our residents Ongoing compliance will be monitored by the Business Office Manager or designee going forward.

The administrator shall monitor and assure ongoing compliance. 5/18/17

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) Thomas Horwanitz

Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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
Department Representatives determined through staff interviews that the facility has 19 residents with mobility needs that would require assistance to evacuate in the event of an emergency. The facility consists of two floors with residents residing on both floors. The first floor has a secured dementia care unit where 13 residents reside. All 13 have a mobility need based on their cognitive ability. It was determined that residents #4,5,6,7,and 8 require the assistance of two staff persons to transfer the residents out of bed/chair and also one person to assist the residents to ambulate in each resident's wheelchair. Residents # 9,10 and 11 require the assistance on one person to transfer the residents out of bed/chair and also one person to assist the residents to ambulate in each resident's wheelchair. Resident #12 has a visual impairment and requires the assistance of one staff person to guide the resident. The facility has five separate internal fire safe stair towers that residents evacuate to during an emergency. Department Representatives reviewed the facility's staffing schedule and determined that on 4/1/17 from 11:00pm to 7:00am the facility had only 3 staff working at the facility. On 4/2/17 from 11:00pm to 7:00am the facility had only 4 staff working at the facility. Based upon the care needs of the residents and each resident's mobility needs, 4 staff is not sufficient to safely transfer, evacuate, supervise and account for each resident during an emergency evacuation. In addition the facility regularly schedules only one staff person to work in the Secured Dementia Care Unit from 11:00pm to 7:00am. Residents # 6,9, and 12 require physical assistance to evacuate the building. One staff person working in the secured dementia care unit is not sufficient to safely transfer, evacuate, supervise, and account for each resident considering the magnetic locking mechanism will release upon an emergency allowing residents to exit the facility to unsafe areas while the one staff is assisting residents out of bed.

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 facility is in the process of hiring and training additional staff. Daily staffing schedules are reviewed to assure resident's needs are being provided as outlined in the resident assessment and support plan. Daily staffing will be monitored by the Resident Care Director or designee going forward to ensure compliance.

The administrator is responsible for ongoing compliance.
[initials] 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/27/2016	10/04/2016	12/13/2016

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Horwitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 7/25/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.63(a) - At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

2a. DESCRIPTION OF VIOLATION
On 4/1/2017 only 1 staff person on the 11pm to 7am shift had both CPR and First Aid training. Based on the number of residents in the home at that time the home was required to have at least 2 staff persons with CPR and First Aid training.

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.

All clinical staff will be trained by a certified instructor by July 1st, 2017. Until this time period, the RCD will assure a minimum of two people per shift will have current first aid and CPR certification. Ongoing compliance will be monitored by the Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
m 5/18/17

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) Thomas Howanitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600

2600.65(f) - Training topics for the annual training for direct care staff persons shall include the following:
(1) Medication self-administration training.
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
(3) Care for residents with dementia and cognitive impairments.
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.
(6) Safe management techniques.
(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person D hired on [redacted]14 did not receive training in Medication self-administration training; instruction on meeting the needs of the resident's as described in the preadmission screening form, assessment tool, medical evaluation and support plan; Infection Control; personal care service needs of the resident; and safe management techniques during the 2016 calendar year.

Direct care staff person E hired on [redacted]10 did not receive training in medication self-administration training; instruction on meeting the needs of the resident's as described in the preadmission screening form, assessment tool, medical evaluation and support plan; personal care service needs of the resident; and safe management techniques during the 2016 calendar year.

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.

Direct care staff person "D" who was out on Medical Leave of Absence has resigned her position on Wednesday [redacted] 2017.

Direct care staff person "E" is scheduled to receive along with all staff annual training. All staff will receive training on the state required topics throughout the 2017 calendar year. Copy of the 2017 training calendar is attached. Ongoing compliance will be monitored by the Business Office Manager or designee going forward.

The administrator shall train Staff person "D" on the elements of this regulation for training year 2016, as well as, 2017. Documentation of the training shall be maintained by the home and available by the Department for review. [initials] 5/18/17

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) Thomas Adwanitz	**Date** 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction Implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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 person D hired on [redacted]14 did not receive training in Fire Safety completed by a fire safety expert, emergency preparedness procedures, resident rights, the Older Adult Protective Services Act, or falls and accident prevention during the 2016 calendar year.

Direct care staff person E hired on [redacted]10 and Ancillary staff person F hired on [redacted]15 did not receive fire safety training completed by a fire safety expert during the 2016 calendar year.

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.

Direct care staff person "D" who was out on Medical Leave of Absence has resigned her position on Wednesday [redacted] 2017.

Direct care staff person "E" and "F" is scheduled to receive along with all staff annual training. All staff will receive training on the state required topics throughout the 2017 calendar year. Copy of the 2017 training calendar is attached. Ongoing compliance will be monitored by the Business Office Manager or designee going forward.

- The administrator shall train staff persons "E + F" on the elements of this regulation for training year 2016, as well as 2017. Documentation of the training shall be maintained by the home and available by the Department for review. [initials] 5/18/17

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) Thomas Howanitz	Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)	Plan of correction implementation status as of 5/24/17 (Date)
The above plan of correction was approved by [initials] (Initials)	☐ Fully Implemented ☒ Partially Implemented - Adequate Progress ☐ Partially Implemented - Inadequate Progress ☐ Not Implemented

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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
At the time of the initial walk through the door to the Housekeeping room located in the basement was left wide open and therefore accessible to residents. The room contained numerous poisonous materials including Medline Surface cleaner, Heavy Duty bowl cleaner, Spotzyme, and Clorox bleach cleaner. Not all residents of the home are assessed to safely use and avoid poisonous materials.
The door to the maintenance room also located in the basement was wide open as well and also contained poisonous materials including Nubrite and Goof Off.

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.

Poisonous materials will be kept in a locked room inaccessible to residents. An in-service will be conducted with the housekeeping staff on the importance of maintaining products in a safe location and locking the door immediately upon exiting the room by May 15th, 2017. Ongoing compliance will be monitored by the Director of Maintenance or designee going forward

The administrator shall monitor and assure ongoing compliance.
5/18/17

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 Thomas Howard ITZ
(Required on EVERY Page)
Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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 telephone located in the basement next to the general storage room does not have emergency numbers posted next to it.

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.

Immediately a list of emergency phone numbers was attached to the telephone located in the basement upon identification. Compliance will be monitored by Director of Maintenance or designee going forward.

- The administrator shall monitor and assure ongoing compliance. [initials] 5/18/17

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): Thomas Horwitz — Date: 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION
The initial medical evaluation for resident #13, dated [redacted]16, does not include the resident's medications. It states "see electronic print out" but there is nothing attached or with the DME in the plastic sleeve.

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 medical evaluation for resident #13 was updated on April 20th, 2017 to include the residents medications, copy attached. Ongoing compliance will be monitored by the Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
[initials] 5/18/17

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) Thomas Horwitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.183(e) - Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

2a. DESCRIPTION OF VIOLATION
Department Representatives completed an audit of the facility's medication cart. Observed at the bottom of the medication cart drawer was a loose pill determined to be Xarelto 20mg. The facility is responsible for the safe, organized and sanitary storage of resident medications.

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.

Staff will complete weekly med cart audit and cleaning. Any lose medications will be disposed of properly. Ongoing compliance will be monitored by Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance. [initials] 5/18/17

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) Thomas Howanitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION
Resident # 14 has a physician's order for blood glucose readings twice daily on Mondays, Wednesdays, and Fridays. On 4/7/17 at 7:12am the blood glucose reading in the meter was 93 but was recorded on the MAR as 132.

Resident # 15 has a physician's order for blood glucose readings twice daily, fasting and at 8pm. Resident # 15's blood glucose readings were incorrectly recorded on the MAR as follows:
On 4/18/17 at 9:26pm the BG meter reading was 112 and recorded on the MAR as 186
On 4/16/17 at 9:05pm the BG meter reading was 169 and recorded on the MAR as 168
On 4/14/17 at 9:11pm the BG meter reading was 158 and recorded on the MAR as 210
On 4/11/17 at 8:30pm the BG meter reading was 190 and recorded on the MAR as 210
On 4/06/17 at 9:08pm the BG meter reading was 129 and recorded on the MAR as 139
On 4/05/17 at 3:03pm the BG meter reading was 213 and recorded on the MAR as 243

Resident # 13 is prescribed Humalog Insulin based upon a sliding scale of the resident's blood glucose levels. On 4/17/17 the resident's blood glucose level was tested to be 147. The facility incorrectly documented 117 on the resident's Medication Administration Record (MAR).

Resident # 16 has a physician's order for blood glucose readings 4 times daily. Resident # 16's blood glucose readings were incorrectly recorded on the MAR as follows:
On 4/10/17 at 8pm the BG meter reading was 189 and recorded on the MAR as 183
On 4/12/17 at 4pm the BG meter reading was 167 and recorded on the MAR as 201
On 4/12/17 at 8pm the BG meter reading was 200 and recorded on the MAR as 167
On 4/14/17 at 8pm the BG meter reading was 199 and recorded on the MAR as 156

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.

No residents suffered any ill effects from the mis-documentation of blood glucose readings. Both employees involved received verbally counseling on April 19th, 2017 and written counseling on May 15th, 2017. Both employees were informed that further infractions will result in disciplinary action leading to possible termination. Copies of the disciplinary action are attached. Ongoing compliance will be monitored for completeness by Resident Care Director or designee going forward.

• The administrator shall be responsible for ongoing compliance.

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

Signature of Legal Entity Representative
(Required on EVERY Page) [signature] [initials] 5/18/17

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Horvanitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 6/20/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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

2a. DESCRIPTION OF VIOLATION
Resident #3, date of admission [redacted]17, is prescribed Lidocaine 5% patch, one patch to skin daily, remove and discard patch within 12 hours, 6am and 6pm. On the date of the inspection, 4/19/17, this medication was not available in the home. The resident had not received the medication from 4/8/17 through 4/19/17. The resident is also prescribed Lovastatin 20mg, one tablet by mouth daily at 9pm. This medication was not available in the home and not administered from 4/8/17 through 4/14/17.

Resident # 16 is prescribed to have blood glucose monitoring completed 4 times daily. On 4/18/17 at 8pm this was not 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.

No residents suffered any ill effects from late administration of medication. New process was initiated on Monday May 1st to assure timely medication distribution. Ongoing compliance will be monitored for completeness by Resident Care Director or designee going forward.

The administrator shall monitor for ongoing compliance.
m 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/15/2016		

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Thomas Horowitz — Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

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

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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
The initial support plan for resident #13 was updated [redacted]17 and [redacted]17 after the resident had falls. The update didn't include the frequency with regards to how often the responsible parties will ensure the needs are met.

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 #13 support plan was updated on April 20th, 2017. Copy of the support plan is included. Ongoing compliance will be monitored for completeness by Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
[initials] 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/15/2016	10/28/2016	12/13/2016

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Horowitz

Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

Violation Report: 22205 - 04/19/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600
2600.227(g) - Individuals who participate in the development of the support plan shall sign and date the support plan.

2a. DESCRIPTION OF VIOLATION
Resident #13's support plan dated 1/3/16 does not have the signature of the resident and there is nothing checked to indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign. The resident did sign their contract dated 12/21/16.

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.

Resident #13 support plan was signed by the resident on April 19th, 2017 Copy of the signature sheet is included. Ongoing compliance will be monitored for completeness by Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.

[signature] 5/18/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	12/13/2016		

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Thomas Horowitz

Date 5/16/17

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

The above plan of correction is approved as of 5/18/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 5/24/17 (Date)

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

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

PCH Name: LEHIGH COMMONS	License Number: 22205
Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062	County: Lehigh
Administrator: Thomas Howanitz	Region: NORTHEAST

Legal Entity Name: 1680 SPRING CREEK ROAD OPERATIONS LLC

Legal Entity Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062

Certificate(s) of Occupancy

C-2 LP
12/19/1997
PA Dept of L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 82	Waking Staff: 62
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Interim

On-Site Inspections Dates and Department Representatives On-Site

05/24/2017: Foulkes, Kimberli; Hummel, Jesse

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: 80

Number of Residents Served: 63

Secured Dementia Care Unit in Home: Yes

Area: n/a

Secured Dementia Unit Capacity, if Applicable: 14

Number of Residents Served in Secured Dementia Care Unit, if applicable: 14

Number of Current Hospice Residents: 2

Number of Hospice Residents in past year: 2

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 63

Have Mental Illness: 0

Have an Intellectual Disablity: 0

Have a Mobility Need: 19

Have a Physical Disability: 1

Violation Report: 22205 - 05/24/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

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

Department Representatives determined through staff interviews that the facility has 19 residents with mobility needs that would require assistance to evacuate in the event of an emergency. The facility consists of two floors with residents residing on both floors. The first floor has a secured dementia care unit where 13 residents reside. All 13 have a mobility need based on their cognitive ability. It was determined that residents #1, 2, 3, 4, and 5 require the assistance of two staff persons to transfer the residents out of bed/chair and also one person to assist the residents to ambulate in each resident's wheelchair. Residents # 6, 7, and 8 require the assistance on one person to transfer the residents out of bed/chair and also one person to assist the residents to ambulate in each resident's wheelchair. Resident # 9 has a visual impairment and requires the assistance of one staff person to guide the resident. The facility has five separate internal fire safe stair towers that residents evacuate to during an emergency. Department Representatives reviewed the facility's staffing schedule and determined that on 5/20/17 and 5/21/17 from 11:00pm to 7:00am the facility had only 3 staff working at the facility. On 4/5/22/17 from 11:00pm to 7:00am the facility had only 4 staff working at the facility. Based upon the care needs of the residents and each resident's mobility needs, 4 staff is not sufficient to safely transfer, evacuate, supervise and account for each resident during an emergency evacuation. In addition the facility regularly schedules only one staff person to work in the Secured Dementia Care Unit from 11:00pm to 7:00am. Residents # 3,6, and 9 require physical assistance to evacuate the building. One staff person working in the secured dementia care unit is not sufficient to safely transfer, evacuate, supervise, and account for each resident considering the magnetic locking mechanism will release upon an emergency allowing residents to exit the facility to unsafe areas while the one staff is assisting residents out of bed.

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.

We are assessing current residents with mobility needs to determine the need for a higher level of care. At this time we will not admit any new residents with mobility needs. The facility is actively recruiting and training staff for the 11-7 shift. Daily staffing schedules are reviewed to assure resident's needs are being provided as outlined in the resident assessment and support plan. Daily staffing will be monitored by the Resident Care Director or designee going forward to ensure compliance.

The administrator shall monitor the staffing schedule daily and assure ongoing compliance.
M 6/20/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):		12/13/2016	10/04/2016

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Thomas Howanitz — Date: 6/20/17

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

The above plan of correction is approved as of 6/20/17 (Date)

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

Plan of correction implementation status as of 6/20/17 (Date)

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

Violation Report: 22205 - 05/24/2017 - Foulkes, Kimberli
PCH Name: LEHIGH COMMONS

1. REGULATION 55 Pa.Code §2600

2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

The home did not implement procedures for the safe use of medical equipment. Resident #10 receives accu checks 4 times daily. The resident's blood glucose level in the glucometer for 5/20/17 at 4:30pm was 269. The blood glucose level recorded on the Medication Administration Record (MAR) on 5/20/17 at 4:30 pm was 286. The resident receives sliding scale insulin at this time and the units and site were not documented as well.

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 residents suffered no ill effects from the mis-documentation of blood glucose readings. The employee involved received written counseling on June 20th, 2017. The employee was informed that further infractions will result in disciplinary action leading to possible termination. Copies of the disciplinary action are attached. Ongoing compliance will be monitored for completeness by Resident Care Director or designee going forward.

The administrator shall monitor and assure ongoing compliance.
[signature] 6/20/17

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) Thomas Horowitz — Date 6/20/17

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

The above plan of correction is approved as of 6/20/17 (Date)	Plan of correction implementation status as of 6/20/17 (Date)
The above plan of correction was approved by MM (Initials)	☐ Fully Implemented ☐ Partially Implemented - Adequate Progress ☒ Partially Implemented - Inadequate Progress ☐ Not Implemented

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

PCH Name: LEHIGH COMMONS	License Number: 22205
Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062	County: Lehigh
Administrator: Thomas Howanitz	Region: NORTHEAST

Legal Entity Name: 1680 SPRING CREEK ROAD OPERATIONS LLC

Legal Entity Address: 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062

Certificate(s) of Occupancy

C-2 LP
12/19/1997
L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 86	Waking Staff: 65
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Complaint

On-Site Inspections Dates and Department Representatives On-Site

06/28/2017: Harvey, Jason

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: 80

Number of Residents Served: 65

Secured Dementia Care Unit in Home: Yes

Area: 1st Floor

Secured Dementia Unit Capacity, if Applicable: 14

Number of Residents Served in Secured Dementia Care Unit, if applicable: 12

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 9

Number of Residents who:

- Receive Supplemental Security Income: 0
- Are 60 Years of Age or Older: 65
- Have Mental Illness: 1
- Have an Intellectual Disability: 0
- Have a Mobility Need: 21
- Have a Physical Disability: 1

Violation Report: 22205 - 06/28/2017 - Harvey, Jason
PCH Name: LEHIGH COMMONS

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
On 6/17/2017 the facility had 66 residents residing at the facility, 22 of which have a mobility need and would require assistance to evacuate the facility in the event of an emergency. Based upon direct care staff interviews it was determined of the residents with mobility needs, residents # 1,2,3,4,5 and 6 require the physical assistance of two staff members to evacuate the building. Residents # 7, 8, 9 and 10 require physical assistance from one staff person to evacuate the building.

On 6/17/2017 from 11pm to 7am the following day, the facility had only 3 staff working in the building. Based upon staff interviews as well as a review of the staff schedule it was determined that the facility often times has only 3 staff working in the facility from 11pm to 7am.

The facility consists of two floors as well as a wing designated as the secure dementia care unit located on the first floor. The facility contains 5 stairwells that are designated as fire safe areas in which residents can to. Residents reside on both floors. A fire safety expert designated a maximum evacuation time of 7 minutes based upon the design and construction of the building.

Based upon the number of residents at the facility as well as the number of residents that require assistance to evacuate, 3 staff persons is not sufficient to safely evacuate, supervise and account for the residents of the facility in the event an emergency evacuation is required.

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.

60(a)

We continue to assess current residents with mobility needs to determine the need for a higher level of care. The facility is actively recruiting and training staff for the 11-7 shift. Daily staffing schedules are reviewed to assure resident's needs are being provided as outlined in the resident assessment and support plan. Daily staffing will be monitored by the Resident Care Director or designee going forward to ensure compliance.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/10/2017	12/13/2016	10/04/2016

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Thomas Horowitz — Date 7/25/17

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

The above plan of correction is approved as of 7/25/17 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 7/25/17 (Date)

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