pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GAHC3 YORK PA ALF TRS SUB LLC**
LEGAL ENTITY

To operate **SENIOR COMMONS AT POWDER MILL**
NAME OF FACILITY OR AGENCY

Located at **1775 POWDER MILL ROAD, YORK, PA 17403**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **166**
(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 28**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 10, 2017** until **July 10, 2018**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **332100**

Robert E. Robinson
ISSUING OFFICER

Jay Bausch
DIRECTOR

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 5/17

JUL 1 0 2017

Ms. Danielle R. Reed,
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 #: 332100

Dear Ms. Reed:

As a result of the Department of Human Services' annual licensing inspections on April 25, 2017 and April 26, 2017 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.

A regular license is being issued based on the enclosed License Inspection Summary. Your license is enclosed.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17120 | 717.783.3670 | F 717.783.5662 | www.dhs.state.pa.us

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosures
License
License 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 RD, YORK, PA 17403	County: York
Administrator: Jeremy Keiter (Acting)	Region: CENTRAL

Legal Entity Name: GAHC3 YORK PA ALF TRS SUB LLC

Legal Entity Address: 18191 VON KARMAN AVE SUITE 300, IRVINE, CA 92612

Certificate(s) of Occupancy

C-2 LP	VB 26-1A
07/23/2001	10/24/2007
L&I	York Twp.

Staffing Hours

Resident Support: 0 — Total Daily Staff: 118 — Waking Staff: 89

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

Reason(s) for Inspection(s)

Renewal, Provisional

On-Site Inspections Dates and Department Representatives On-Site

04/25/2017: Hoover, Douglas; Springs, Israel
04/26/2017: Hoover, Douglas; Springs, Israel

Off-Site Inspection Dates and Inspectors, If Applicable

RECEIVED
MAY 0 8 2017
CENTRAL REGION FIELD OFFICE

Other Details

Partial or Full Triggers: — Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 166

Number of Residents Served: 93

Secured Dementia Care Unit in Home: Yes

Area: Arlington Court, Rosewood

Secured Dementia Unit Capacity, if Applicable: 28

Number of Residents Served in Secured Dementia Care Unit, if applicable: 22

Number of Current Hospice Residents: 2

Number of Hospice Residents in past year: 5

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 91

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 25

Have a Physical Disability: 0

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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 [redacted]/17, Resident #8 passed away in the home. The home did not submit an incident report to the Department until [redacted]/17.

Resident #9 did not receive ***Lorazepam, 0.5 mg.***, as prescribed, on 2/6/17 and 2/7/17 because of a medication error. The home did not submit an incident report until 2/9/17.

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.

- Summary: The prior practice had the Resident Care Director as the person responsible for faxing a reportable incident to the Department's Personal Care Home Regional Office. This process has caused occurrence where a deadline was not met if this person was out of the facility. A new procedure is now in place. Senior Commons now has a Lead Medication Technician for the day, evening, and night shift. Each of these employees has been trained to complete the incident report and fax it to the appropriate agencies during his/her shift. The Resident Care Director will be alerted through our electronic medical record the moment the report has been submitted. The resident Care Director or designee can review and finalize the Reportable as necessary. This will eliminate the time delay in initial reporting of events.
- Immediate Correction: Lead Med Tech now faxing Incident Reports during shift of occurrence. The Resident Care Director will train the nursing department Lead Med Techs on **the Plan of Correction Training-Nursing Lead Med Techs (Attachment A)** by 6/2/17.
- Who: Lead Medication Technician now has initial notification responsibility.
- When: In place May 8th, 2017 and on-going.
- How: In-Service training was completed and documented for each Lead Medication Technician.
- On-going: Resident Care Director receives all of the Incident Reports with proof of fax times. She will monitor that all of the initial reports are faxed on time. A copy of the reports is then given to the Executive Director for over-sight, follow-up, monitoring, and storage. The Resident Care Director or designee will conduct weekly Quality Assurance (QA) audit of the EMR to review all reportable incidents. **(See Attachment B)** The QA audit findings will be communicated at the quarterly QA Meetings.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/07/2016	09/27/2016	

Signature of Legal Entity Representative (Required on EVERY Page) *Jeremy Keiter*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Jeremy Keiter, PCHA* Date *5/18/17*

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

The above plan of correction is approved as of *6-27-17* (Date)

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

Plan of correction implementation status as of *6-27-17* (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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

There was a "Lab Report" clipboard sitting on a side shelf, accessible from the corridor, at the nurses' station by Apartment #518. The clipboard contained a confidential "metabolic panel" order for Resident #1. Confidential information included the resident's name, date of birth and physician's name.

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.

- Summary: All lab clip boards were removed from the nurse's stations at the time of the survey. Labs to be entered in the EMR to track when labs are due. The labs slips are kept in a secure confidential location where only staff have access. The nurses' stations located off the hallways are now used as temporary work stations when needed, and the person using the station will take all his/her belongings with them when they leave. To ensure ongoing compliance, we will include a search for potential HIPPA violations during our monthly QA checks.
- Immediate Correction: Clip board was removed from the desk while the State Survey was being conducted. The Resident Care Director will train the nursing department on **the Plan of Correction Training-Nursing Department (Attachment C)** by 6/2/17.
- Who: Medication Technicians
- When: In place April 27th, 2017 and on-going.
- How: All physical medical information is now located in a secure confidential location where only staff have access.
- On-going: HIPPA training is given within 30 days of new hire and is given annually thereafter. HIPPA oversight will also be a part of the monthly QA completion.

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) Jeremy Keifer, PCHA — Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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.

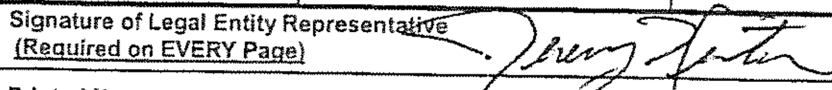
2a. DESCRIPTION OF VIOLATION
The contract for Resident #2, dated [redacted]16, was not signed by the resident. There was no notation of refusal or inability to sign for Resident #2.

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.

- Summary: Resident #2 is a Memory Care Resident. A notation should have been made stating that the resident was unable to sign or have the resident sign.
- Immediate Correction: Resident #2 signed [redacted] agreement. An audit was completed to check all resident agreements for necessary signatures **(See Attachment D).** The Executive Director will train the administrative team on **the Plan of Correction Training-Executive Director Designee (Attachment E)** by 6/2/17.
- Who: Executive Director or designee (most often Business Office Manager or Marketing Director) will complete and execute all Resident Agreements.
- When: A complete audit of all current Agreements was completed. Any prior agreements not signed by the resident were taken to the resident to sign, if able. The executive director or designee will sign all resident agreements within 24 hours and will ensure residents and/or designee will sign. A note of refusal will be documented if necessary. All new residents will sign as he Executive Director, Business Office Manager, or Marketing Director will complete a future Agreement executions.
- How: They will be executed and checked prior to physical move in.
- On-going: All new residents will sign as he Executive Director, Business Office Manager, or Marketing Director will complete a future Agreement executions. The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits **(See Attachment F).** The QA audit findings will be communicated at the quarterly QA Meetings.

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

Signature of Legal Entity Representative (Required on EVERY Page)



Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jeremy Keiter, PCHA Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION
On 4/25/17, the fire exit door by Apartment #579 was wedged/warped shut and required two people to open the door. Once opened, the door would not close properly. The condition of the door obstructed and prevented free egress outside for the residents.

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

- Summary: The exit door was not in proper working order. We had heavy rain in the days prior to the inspection causing the door sill to expand which did not allow the door to open or close properly. It was fixed within hours of the State Surveyor discovering it.
- Immediate Correction: It was fixed immediately. The Maintenance Director will train the maintenance department on **the Plan of Correction Training-Maintenance Designee (Attachment J)** by 6/2/17.
- Who: The Maintenance Director.
- When: April 26, 2017.
- How: The sill was altered to allow it to swell from moisture but not interfere with the function of the door.
- On-going: All egress doors are checked with each monthly fire drill. The Maintenance Director or designee will conduct monthly Quality Assurance (QA) audits **(See Attachment H)** and monthly Safety Audits **(See Attachment I)**. The QA audit findings will be communicated at the quarterly QA Meetings and the monthly Safety Meetings.

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

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Jeremy Keiter, PCHA

Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600

2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION

The home does not have a current designated evacuation time from a fire safety expert. The last fire safety letter from a fire safety expert is dated 1/15/16. The home's fire drill evacuation times are as follows:

11/21/16 - 9 minutes 15 seconds
12/21/16 - 6 minutes 15 seconds
1/11/17 - 7 minutes 0 seconds
2/17/17 - 10 minutes 0 seconds
3/17/17 - 5 minutes 45 seconds
4/17/17 - 4 minutes 12 seconds

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.

- Summary: There wasn't a current letter from a fire expert designating the allotted time for residents to evacuate the building. The most recent letter on file was 1/15/16. These letters are only valid for one year.
- Immediate Correction: A letter was obtained May 9, 2017 **(See attachment K)** The Maintenance Director will ensure the Maintenance Department obtains the Fire Expert Letter annually as well as train the maintenance department on **the Plan of Correction Training-Maintenance Designee (Attachment L)** by 6/2/17.
- Who: The Maintenance Director will obtain this letter from The Goodwill Fire Company #1 York Township-Station 19.
- When: Prior to the 1 year expiration of the previous letter
- How: By contacting the fire department 3 months prior of the due date and scheduling a meeting to obtain a new letter prior to the expiration of the previous one.
- On-going: The Maintenance Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Jeremy Keiter, PCHA

Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600

2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION

The initial medical evaluation for Resident #5, admitted [redacted]16, was completed on [redacted]16. The following medical evaluation was dated 4/19/17, more than a year later.

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.

- Summary: A medical evaluation was dated later than the one year allotment of the previous one.
- Immediate Correction: The Resident Care Director audited all the current resident's medical evaluations on 5/12/17 **(See Attachment M).** There was one resident medical evaluation needing to be completed (it is circled on the audit and an appointment with the physician is scheduled for 5/17/17 to have it completed). Appointments were scheduled with the resident's primary care physician to obtain a current medical evaluation for upcoming medical evaluations which are due. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment N)** by 6/2/17.
- Who: Resident Care Coordinator to coordinate the resident appointments for the completion of the medical evaluation.
- When: The month prior to the expiration date the appointment will be scheduled with the resident's physician.
- How: A report will be pulled from the electronic medical record to see what medical evaluations will be coming due next month. **(See Attachment M)**
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Jeremy Keiter, PCHA — Date: 5/18/17

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The above plan of correction is approved as of 6-27-17 (Date)

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.190(b) - A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

2a. DESCRIPTION OF VIOLATION
Resident #6 received insulin injections from Direct Care Staff Member A on 4/5/17, 4/11/17 and 4/12/17. Staff Member A's certificate for administering insulin injections was dated 1/26/16.

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.

- Summary: All Med Techs must take and pass the diabetic training every 12 months. A Med Tech was administering insulin without being trained in the allotted time period.
- Immediate Correction: The Med Tech was immediately removed from the med pass and scheduled to a med pass that didn't have any resident's receiving insulin injections until receiving the diabetic training **(See Attachment O).** The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Med Techs (Attachment H)** by 6/2/17.
- Who: The Resident Care Director or designee will coordinate when the Med Techs will need to receive the diabetic training.
- When: The Med Techs will be trained every 12 months. The Med Tech identified in this violation was trained May 16, 2017.
- How: Any Med Tech administering insulin to a resident must have a current completion of the diabetic training.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Jeremy Koiter, PCHA

Date 5/18/17

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

The above plan of correction is approved as of 6-27-17 (Date)

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.225(a) - A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

2a. DESCRIPTION OF VIOLATION
The initial assessment for Resident #2 was dated ▇▇▇/17. Resident #2 was admitted to the secure dementia care unit (SDCU) on ▇▇▇/16.

The initial assessment for Resident #3 was dated ▇▇▇/16. Resident #3 was admitted on ▇▇▇/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.

- Summary: Two residents didn't have an assessment completed within 15 days of admission.
- Immediate Correction: The assessments for each resident was completed late for both residents. We can't change the date on the existing assessment but moving forward the completion date will now serve as the new due annual date. The completion date will serve as the new due annual date. The Resident Care Director audited all the current resident's initial RASP on 5/17/17 **(See Attachment M)** There were 4 annual assessments needing to be completed. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment Q)** by 6/2/17.
- Who: The Resident Care Director or designee will coordinate the completion of the resident's initial assessment within the allotted timeframe.
- When: The resident's initial assessment will be completed within 15 days of admission. If the resident is admitted to a secure dementia unit it will be done within 72 hours.
- How: Every resident admitted will have an initial assessment completed timely.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Jeremy Keifer, PCHA **Date** 5/18/17

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The above plan of correction is approved as of 6-27-17 (Date)

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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 initial assessment for Resident #5, admitted [redacted]/16, was dated [redacted]/16. The following assessment was dated 4/24/17, more than a year later.

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.

- Summary: A resident didn't have an annual RASP completed within 1 year of the expiring one.
- Immediate Correction: The RASP for the resident was completed past the annual date. We can't change the date on the existing RASP but moving forward the completion date will now serve as the new due annual date. The Resident Care Director audited all the current resident's initial RASP on 5/17/17 **(See Attachment M)** There were 4 annual assessments needing to be completed. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment Q)** by 6/2/17.
- Who: The Resident Care Director or designee will coordinate the completion of the resident's annual RASP within the 1 year timeframe.
- When: The resident's RASP must be completed every year prior to the current RASP expiring.
- How: Every current resident will have an annual RASP completed timely.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the QA Meetings.

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

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

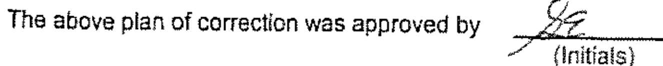
Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Jeremy Keiter, PCHA — Date: 5/18/17

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

The above plan of correction is approved as of 6-27-17 (Date)

Plan of correction implementation status as of 6-27-17 (Date)

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



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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.227(a) - A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

2a. DESCRIPTION OF VIOLATION
The initial support plan for Resident #3 was dated [redacted]16. Resident #3 was admitted on [redacted]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.

- Summary: A residents didn't have a RASP implemented within 30 days of admission.
- Immediate Correction: The RASP for the resident was completed on [redacted]16, one month late. We can't change the date on the existing RASP but moving forward the completion date will now serve as the new due annual date. The Resident Care Director audited all the current resident's initial RASP on [redacted]17 **(See Attachment M)** There were 4 annual RASP needing to be implemented. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment S)** by 6/2/17.
- Who: The Resident Care Director or designee will coordinate the implementation of the resident's initial RASP within 30 days.
- When: The residents initial RASP will be implemented within 30 days of admission.
- How: Every resident admitted will have an initial RASP completed timely.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jeremy Keiter, PCHA | Date 5/18/17

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

The above plan of correction is approved as of 6-27-17 (Date)

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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.

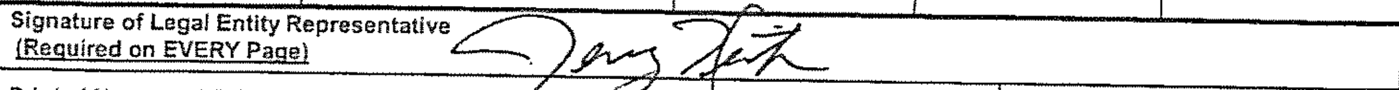
2a. DESCRIPTION OF VIOLATION
Resident #7 was admitted to the SDCU on [redacted]17. There is no evaluation date on the medical evaluation form.

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.

- Summary: A medical evaluation wasn't completed properly and as evidence by a missing evaluation date.
- Immediate Correction: The resident's medical evaluation was completed on [redacted]/17 **(See Attachment U).** We can't change the date on the existing medical evaluation but moving forward for resident #7 the annual completion date will now be [redacted] 2018. The Resident Care Director audited all of the residents' initial medical evaluation on [redacted]/17 **(See Attachment M)** There were no other initial medical evaluations needing to be completed. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment T)** by 6/2/17.
- Who: Resident Care Director or designee will assure the medical evaluation completed on SDCU residents within 60 days prior to admission.
- When: Prior to admission
- How: By communicating with the family and primary care physician to ensure it is completed timely.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

Signature of Legal Entity Representative
(Required on EVERY Page)



Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Jeremy Keifer, PCHA

Date 5/18/17

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The above plan of correction is approved as of 6-27-17 (Date)

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

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 #2 was admitted to the SDCU on [redacted]/16. The home has no documentation that Resident #2 and the resident's designated person did 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.

- Summary: There was no documentation in the resident record that stated the resident and the resident responsible party had no objection to a SDCU placement.
- Immediate Correction: A phone call was made to the responsible Party to confirm [redacted] had no objection and an in person visit to the resident to do the same. This was documented in the resident's record. **(See Attachment W)** The Executive Director will train the administrative team on **the Plan of Correction Training-Executive Director Designee (Attachment V)** by 6/2/17.
- Who: The Executive Director or Designee will assure during admission that the resident and Responsible Party have no objection and the chart will reflect that documentation. The Resident Care director or designee will ensure that the resident will be assessed annually for the continued need for an SDCU placement and the Chart will reflect such.
- When: Prior to admission and annually
- How: By communicating with the resident and resident responsible party.
- On-going: The Executive Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the quarterly QA Meetings.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jeremy Keifer, PCHA — Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.231(h) - The resident-home contract in § 2600.25 (relating to resident-home contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

2a. DESCRIPTION OF VIOLATION
Resident #3 was admitted to the SDCU on [redacted]/17. There was no addendum or language in the contract, dated [redacted]/16, that disclosed services, admission and discharge criteria, special programming and fees for the secure dementia care unit.

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.

- Summary: When the resident was transferred to the SDCU on [redacted]/17 the description of services, admission and discharge criteria, and special programming and fees for the SDCU were not signed **(See Attachment X).**
- Immediate Correction: On 4/26/17 attachment X was signed by the resident and responsible party. The Executive Director will train the administrative team on **the Plan of Correction Training-Executive Director Designee (Attachment Y)** by 6/2/17.
- Who: Executive Director or Designee
- When: Will ensure all resident agreements and pertinent addendums are signed within 24 hours of admission.
- How: By meeting with the resident and resident responsible party.
- On-going: The Executive Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the QA Meetings.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jeremy Keiter, PCHA Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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

Violation Report: 33210 - 04/25/2017 - Hoover, Douglas
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.234(a) - Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

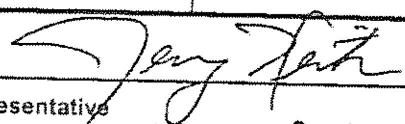
2a. DESCRIPTION OF VIOLATION
Resident #2, admitted to the SDCU on [redacted]/16, did not have a support plan developed until [redacted]17.

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.

- Summary: Resident # 2 didn't have a support plan developed within 72 hours of admission.
- Immediate Correction: The support plan for the resident was completed on [redacted]/16, which was late. We can't change the date on the existing support plan but moving forward the completion date will now serve as the new due annual date. The Resident Care Director audited all the current resident's initial RASP on [redacted]17 **(See Attachment M)** There were 4 annual RASP needing to be implemented. The Resident Care Director will train the nursing department designee on **the Plan of Correction Training-Nursing Designee (Attachment Z)** by 6/2/17.
- Who: Resident Care Director or designee
- When: Within 72 hours of admission
- How: A timely assessment will be completed with a support plan to follow, generated in our EMR.
- On-going: The Resident Care Director or designee will conduct monthly Quality Assurance (QA) audits. The QA audit findings will be communicated at the QA Meetings.

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

Signature of Legal Entity Representative
(Required on EVERY Page)



Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Jeremy Keiter, PCHA	Date 5/18/17

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

Plan of correction implementation status as of 6-27-17 (Date)

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