pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **ABOVE AND BEYOND AT THE KNIGHTS LLC**
(LEGAL ENTITY)

To operate **ABOVE & BEYOND AT THE KNIGHTS**
(NAME OF FACILITY OR AGENCY)

Located at **1545 GREENLEAF STREET, ALLENTOWN, PA 18102**
(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 **150** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 32

PROVISIONAL

Restrictions:

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 **June 26, 2017** until **December 26, 2017**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226471**

Robert E. Robinson
ISSUING OFFICER

Jay Bank
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

pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUN 26 2017

Mr. Nader Hamati,
Officer
Above & Beyond at The Knights
4293 Chatter Way
Allentown, Pennsylvania 18103

RE: Above & Beyond at The Knights
1545 Greenleaf Street
Allentown, Pennsylvania 18102
License #: 226471

Dear Mr. Hamati:

As a result of the Department of Human Services' licensing inspections on March 9, 2017 and March 17, 2017 of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa.Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time. The licensing inspector was unable to complete a full inspection because this is a new legal entity operating the home.

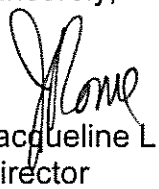
During the inspection, violations on the enclosed License Inspection Summary were found. All violations specified on the License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your PROVISIONAL license is enclosed, based on substantial but not complete compliance with 55 Pa.Code Ch. 2600.

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

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 applicant 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: ABOVE & BEYOND AT THE KNIGHTS	License Number: 22647
Address: 1545 GREENLEAF STREET, ALLENTOWN, PA 18102	County: Lehigh
Administrator: Brian Hofsass	Region: NORTHEAST
Legal Entity Name: ABOVE & BEYOND AT THE KNIGHTS	
Legal Entity Address: 4293 CHATTER WAY, ALLENTOWN, PA 18103	

Certificate(s) of Occupancy

C-2 LP
04/12/1989
PA Dept of L&I

Staffing Hours

Resident Support: 0 | Total Daily Staff: 121 | Waking Staff: 91

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

Reason(s) for Inspection(s)

Renewal, New

On-Site Inspections Dates and Department Representatives On-Site

03/09/2017: Foulkes, Kimberli; Dumas, Gerald
03/17/2017: Foulkes, Kimberli; Dumas, Gerald

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: | Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 150

Number of Residents Served: 87

Secured Dementia Care Unit in Home: Yes

Area: 1st floor

Secured Dementia Unit Capacity, if Applicable: 32

Number of Residents Served in Secured Dementia Care Unit, if applicable: 24

Number of Current Hospice Residents: 2

Number of Hospice Residents in past year: 16

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 86

Have Mental Illness: 3

Have an Intellectual Disability: 6

Have a Mobility Need: 34

Have a Physical Disability: 6

22647

Violation Report: ~~21655~~ 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

2a. DESCRIPTION OF VIOLATION
On 3/9/17 binders containing confidential resident information such as care plans/care profiles were unlocked and accessible on the 2nd and 3rd floors in the cabinets above the sinks in the resident kitchenette areas.

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.

<See attached POC & supporting documentation>

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

Signature of Legal Entity Representative (Required on EVERY Page) RMA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hotsass, Executive Director — **Date** 4/27/17

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

The above plan of correction is approved as of 5/2/17 (Date)

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

[redacted]

[redacted] Sep 5.2017

The home has a natural gas fire place in the library. the carbon monoxide detector installed on the ceiling is less than 15ft from the source.

As a result, the home has failed to comply 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.

(See attached POC & supporting documentation)

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) Brian Hotaas, Executive Director — Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21855~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.42(s) - A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

2a. DESCRIPTION OF VIOLATION
Video recording inside the home is only permitted in areas completely inaccessible to residents. On 3/9/17 the home had cameras recording on the 2nd floor near the elevators, near the womans common bathroom, and in the activity/common room. The first and third floor cameras were not recording. The second floor areas that were being recorded were the hallway from the elevator to the exit door by room 227, the hallway facing the employee entrance, the hallway facing the main entrance, the main entrance and the activity/common room.

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.

< See attached POC & supporting documentation >

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) Brian Jofiss, Executive Director

Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21855~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600

2600.65(a) - Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

2a. DESCRIPTION OF VIOLATION

Staff person A, whose first day of work was [redacted]16, did not receive orientation in 1 through 7.

Staff person B, whose first day of work was [redacted]17, did not receive orientation in 1 through 7.

Staff person C, whose first day of work was [redacted]/17, did not receive orientation in 1 through 7.

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.

<See attached POC & supporting documentation>

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) Brian Hotsgss, Executive Director **Date** 4/27/17

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Plan of correction implementation status as of 5/2/17 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600

2600.65(b) - Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.

2a. DESCRIPTION OF VIOLATION

Ancillary staff person A, date of hire [redacted]16, did not receive orientation in 1 through 4.

Direct Care staff person B , date of hire [redacted]17, did not receive orientation in 1 through 4.

Direct Care staff person C, date of hire [redacted]17, did not receive orientation in 1 through 4.

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.

<See attached POC & supporting documentation>

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) Brian Hofsass, Executive Director

Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.65(a) - Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

2a. DESCRIPTION OF VIOLATION
Ancillary staff person A, who began work on [redacted]16, did not receive a general orientation to their job functions.

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.

(See attached POC & supporting documentation)

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

Signature of Legal Entity Representative (Required on EVERY Page) BM

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Bryan Hetsess, Executive Director

Date 4/27/17

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The above plan of correction is approved as of 5/2/17 (Date)

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

Plan of correction implementation status as of 5/2/17 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

The annual training provided to direct care staff person D in training year 2016 did not include training in 1) medication self administration training, and 2) Instruction on meeting the needs of the resident's as described in the required forms.

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.

< See attached POC & Supporting documentation >

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/09/2016		

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hartzell, Executive Director

Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

Ancillary staff person E did not receive training in 4) The Older Adult Protective Services Act during training year 2016. Ancillary staff person F did not receive training in 3) Resident Rights and 4) The Older Adult Protective Services Act during training year 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.

(See attached POC & Supporting documentation)

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/09/2016		

Signature of Legal Entity Representative (Required on EVERY Page) RM

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hofsass, Executive Director — **Date** 4/27/17

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Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION
On 3/9/17, a blackish/grey fuzzy appearing substance was observed above the 5 heating vents in the library above the book shelves.

On 3/9/17, at approximately 12:15 pm, the 1st floor common men's room had a strong urine odor. At the exit conference staff person G stated that - it was determined the urine odor came from a drain.

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.

(See attached POC & supporting documentation)

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

Signature of Legal Entity Representative (Required on EVERY Page) RMH

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Bryan Hobbs, Executive Director — Date 4/27/17

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

The above plan of correction is approved as of 5/2/17 (Date)

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli

PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600

2600.88(a) - Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION

On 3/9/17, water damaged ceiling tiles and missing ceiling tiles were observed in the dining area near the windows. When facing the windows that lead to the parking lot the first window from the left has a water damaged ceiling tile to the right of it. The middle window has a section of ceiling tile above it missing that is approximately 4 inches by 24 inches and there are also three other water damaged tiles. According to staff the water comes in from the soffit when it rains. Wet and missing ceiling tiles pose a hazard to the residents due to mold, mildew, and the risk of them falling.

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.

(See attached POC & supporting documentation)

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

Signature of Legal Entity Representative (Required on EVERY Page) RMH

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ryan Hobbs Executive Director

Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21855~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.103(e) - Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

2a. DESCRIPTION OF VIOLATION
On 3/9/17, in the Kenmore refrigerator on the 3rd floor there was an eight ounce can of Green Acres Peaches that was opened and not labeled or dated, a 20 fluid ounce Orange Crush soda that was opened and not labeled or dated, and left over chinese fried rice that was in a plastic take out container, previously served, that was not labeled or dated.

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.

< See attached POC & supporting documentation >

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

Signature of Legal Entity Representative (Required on EVERY Page) N/A

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hotsess, Executive Director — Date 4/27/17

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21055~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION
On 3/9/17, there was an accumulation of lint in the lint trap of the Kenmore Dryer on the left in the laundry located in the homes SCDU used for the 2nd and 3rd floor 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.

<See attached POC & supporting documentation>

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) Brian Hotbass, Executive Director

Date 4/27/17

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

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21685~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION 55 Pa.Code §2600
2600.183(b) - Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2a. DESCRIPTION OF VIOLATION
On 3/9/17, a bottle of hydrogen peroxide was unlocked and accessible to residents in the cabinet above the sink to the left of the refrigerator in the 2nd floor common area.

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.

(See attached POC & supporting documentation)

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

Signature of Legal Entity Representative (Required on EVERY Page) BWH

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hotbass, Executive Director

Date 4/27/17

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

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

Plan of correction implementation status as of 5/2/17 (Date)

- ☐ Fully Implemented
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- ☐ Not Implemented

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

1. REGULATION ~~55 Pa.Code §2600~~
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. ~~DESCRIPTION OF VIOLATION~~
On 3/9/17, hydrogen peroxide, located in the cabinet to the left of the refrigerator in the 2nd floor common area had an expiration date of 2/2009.

On 3/17/17, resident #2's bottle of Natures Bounty D3-5000 had no expiration date on the bottle. It appeared to be rubbed off. There is no way to determine the expiration date of this medication.

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

(See attached POC & supporting documentation)

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) Brian Hobbs, Executive Director

Date 4/27/17

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

The above plan of correction is approved as of 5/2/17 (Date)

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

Plan of correction implementation status as of 5/2/17 (Date)

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

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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 medications. Resident #1 is prescribed HC/2ND/Nysta with Pet Cream, apply to irritation three times daily, 11-7, 7-3, and 3-11. On 3/17/17 this medication was not available in the home.

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.

(See attached POC & supporting documentation)

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) Brian Lobiondo Executive Director

Date 4/27/17

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22647

Violation Report: ~~21665~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

2a. DESCRIPTION OF VIOLATION
Resident #3 is prescribed Lorazepam 0.5mg tablet, 1 tablet by mouth three times daily, 0800, 1400, and 2000. On 3/7/17 at 0800 the medication was held. The home did not obtain a physician's order to hold the medication.

Resident #1 is prescribed HC/2ND/Nysta with Pet Cream, apply to irritation three times daily, 11-7, 7-3, and 3-11. On 3/17/17 this medication was not in the home. The home failed to administer this medication on 3/17/17 11-7 and 7-3.

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.

<See attached POC & supporting documentation>

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/09/2016		

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Brian Hoffass, Executive Director

Date 4/27/17

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22647

Violation Report: ~~21665~~ - 03/09/2017 - Faulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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

Resident # 2's Resident Assessment Support Plan / Personal Service Plan dated 1/20/17 did not address the resident's pattern of three recent fall incidents on 2/25/17, 3/4/17 and 3/6/17. Additionally, the RASP did not address the resident's declining health which includes a loss of appetite.

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.

<See attached POC & supporting documentation>

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)	Ryan Hotzes Executive Director		Date 4/27/17	

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- ☐ Not Implemented

22647

Violation Report: ~~21656~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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
Resident # 4 is receiving home health services. Home health services is not included in the resident's RASP/ Personal Service Plan dated 2/8/17.

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.

<See attached POC & Supporting documentation>

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) [illegible] Executive Director — **Date** 4/27/17

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

22647

Violation Report: ~~21655~~ - 03/09/2017 - Foulkes, Kimberli
PCH Name: EMERITUS AT ALLENTOWN

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 was admitted to the home's Secure Dementia Unit [redacted]17. The Residents Assessment and Support Plan (RASP)/Personal Service Plan was not signed 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.

(See attached POC & supporting documentation)

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) Brian Hopgood, Executive Director

Date 4/27/17

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Emeritus at Allentown

Plan of Correction

The following is the Plan of Correction for Emeritus at Allentown regarding the Statement of Deficiency dated April 17, 2017 for the renewal survey on March 9, 2017 and March 17, 2017. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.

Regulation 2600.17

The binders were immediately relocated to the Wellness Office to be maintained confidential in a locked room with only access availability by healthcare professionals. Appropriate staff were re-trained by the Health and Wellness Director on April 21, 2017 regarding the community policy on confidentiality of resident records. The Resident Care Coordinator or designee will audit the cabinets in the resident kitchenette areas on the 2nd and 3rd floor weekly for any resident records for 2 months. The Executive Director or designee will review audit results monthly to verify if any further action is warranted.

Evidence: training attendance sheets

Completion Date: April 21, 2017

5/2/17

Regulation 2600.18.

The community's carbon monoxide detectors were all installed according to manufacturer's guidelines which instruct the community to place the device not less than 15 feet from the fossil burning device. The one detector in the library was reinstalled to be 15 feet from the heat source. Further, following consultation with the community's Fire and Life Safety Expert, the community confirmed the Care Facility Carbon Monoxide Alarms Standards Act only requires the community to place a carbon monoxide detector not less than 15 feet from the fossil burning

device. In addition, the National Fire Protection Association (NFPA) standard only requires the community to have a carbon monoxide detector not less than 15 feet from the fossil burning device and to maintain the installation and maintenance pursuant to the manufacturer's instructions. The NFPA standard does not require the carbon monoxide detector to be in the same room as the fossil burning device, only not less than 15 feet from the fossil burning device.

Community maintains it is and will continue to operate in compliance with the manufactures guidelines and the Care Facility Carbon Monoxide Alarms Standards Act; therefore, the community objects to the application of this violation of Section 2600.18 and requests it is removed from the Violation Report.

Evidence; **manufacturers guidelines for installation of Carbon Monoxide detector**

5/2/17.

Regulation 2600.42(s)

The camera record mode was immediately turned off on the second floor near the elevators, near the woman's bathroom and in the activity/common area. Appropriate staff were re-trained on resident right to privacy of self and video recording. The Executive Director retrained appropriate staff on April 26th, 2017. The Executive Director or designee will review camera usage weekly for 2 months to assure they are not in the record mode, monitoring for compliance and to determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-Staff training attendance log

5/2/17

Completion Date: April 26, 2017

Regulation 2600.65 (a)

Immediately, the Business Office Manager implemented a checklist tool to verify that all of the required associate training documentation is in each file moving forward. Immediately, the Business Office Manager implemented an associate checklist for current and future associates. The Business Office Manager audited current employee files for completion of orientation trainings. The Operations Specialist re-trained appropriate management staff on April 19, 2017 regarding the community policy on orientation in evacuation procedures, staff duties during fire

drills, smoking safety, use of extinguishers, smoke detectors/ alarms and notification of emergency services. The Business Office Manager or designee will audit all new employee files for completion of required trainings monthly for 2 months. The Executive Director or designee will review audit results for the next 2 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-Manager training attendance log

Completion Date-April 19, 2017

5/2/17

Regulation 2600.65 (b)

Immediately, the Business Office Manager implemented a checklist tool to verify that all of the required associate training documentation is in each file moving forward. Immediately, the Business Office Manager implemented an associate checklist for current and future associates. The Business Office Manager audited current employee files for completion of orientation trainings. The Operations Specialist re-trained appropriate management staff on April 19, 2017 regarding the community policy on orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect and reportable incidents. The Business Office Manager or designee will audit all new employee files for completion of required trainings monthly for 2 months. The Executive Director or designee will review audit results for the next 2 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-Manager training attendance log

Completion Date-April 19, 2017

5/2/17

Regulation 2600.65 (c)

Immediately, the Business Office Manager implemented a checklist tool to verify that all of the required associate training documentation is in each file moving forward. Immediately, the Business Office Manager implemented an associate checklist for current and future associates. The Business Office Manager audited current employee files for general orientation to their job function. The Operations Specialist re-trained appropriate management staff on April 19, 2017

regarding the community policy on orientation to job function. The Business Office Manager or designee will audit all new employee files for completion of required trainings monthly for 2 months. The Executive Director or designee will review audit results for the next 2 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-Manager training attendance log

5/2/17

Completion Date: April 19, 2017

Regulation 2600.65 (f)

Immediately, the Business Office Manager implemented a checklist tool to verify that all of the required associate training documentation is in each file moving forward. Immediately, the Business Office Manager implemented an associate checklist for current and future associates. The Business Office Manager audited current employee files for annual direct care staff training. The Operations Specialist re-trained appropriate management staff on April 19, 2017 regarding the community policy on annual training topics required for direct care staff. The Business Office Manager or designee will audit all employee files monthly for completion of required trainings according to schedule in 2017 for 2 months. The Executive Director or designee will review audit results for the next 2 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-manager training attendance log, annual training schedule

Completion Date: April 19, 2017

5/2/17

Regulation 2600.65 (g)

Immediately, the Business Office Manager implemented a checklist tool to verify that all of the required associate training documentation is in each file moving forward. Immediately, the Business Office Manager implemented an associate checklist for current and future associates. The Business Office Manager audited current employee files for annual ancillary staff training. The Operations Specialist re-trained appropriate management staff on April 19, 2017 regarding the community policy on annual training topics required for ancillary staff. The Business Office Manager or designee will audit all employee records for completion of required trainings monthly for 2 months for 2017. The Executive Director or designee will review audit results for

the next 2 months to monitor for compliance and determine if further action is required. The Executive Director will direct additional actions based on audit findings.

Evidence-Manager training attendance log, annual training schedule

Completion Date: April 19, 2017

5/2/17

Regulation 2600.85 (a)

Immediately, the blackish grey fuzz was removed from the vents in the library above the book shelves. Immediately, the first floor common men's bathroom was cleaned. The Maintenance Director installed an automatic flush valve in the bathroom drain in the men's room had to avoid any residual collection of urine in the bottom of the urinals on March 10, 2017. The Operations Specialist re-trained the appropriate staff on April 24, 2017 on the community policy regarding maintaining sanitary conditions throughout the community. These areas will be monitored on weekly environmental rounds by the Maintenance Director or designee. The process and review of need for repairs are monitored by the Maintenance Director or designee via weekly environmental round audits. Executive Director or designee will audit environmental rounds reports for 2 months to verify if further action is required.

Evidence: Staff training, Environmental Rounds audit form
Completion Date: April 26, 2017

5/2/17

Regulation 2600.88 (a)

The wet and damaged ceiling tiles were immediately replaced on March 9, 2017 by the Maintenance Director. The source of the leak was repaired. The appropriate staff were re-trained in the community policy regarding maintaining a home in good repair with a hazard free environment on March 13, 2017 by the Operations Specialist. Maintenance Director or designee via weekly environmental rounds audit will review the cleanliness of the common area men's bathroom and library for any ceiling leaks tiles that need to be replaced due to water damage. The process and review of need for repairs are monitored by the Maintenance Director or designee via weekly environmental round audits. Executive Director or designee will audit environmental rounds reports for 2 months to verify if further action is required.

Evidence: training log sheet, audit form for environmental rounds
Completion Date: April 26, 2017

5/2/17

Regulation 2600.103 (e)

Immediately the opened, not labeled or undated peaches, Orange Crush and Chinese food were discarded on March 9, 2017 by the Health and Wellness Director. Appropriate care staff was retrained in the community policy regarding handling and storage of leftover food by the Operations Specialist on March 10, 2017. Maintenance Director or designee will include in weekly environmental audits the refrigerator on the third floor. The Executive Director or designee will monitor audit results weekly for 2 months to identify if any further action is warranted.

Evidence: Training Attendance sheet

Completion Date: April 26, 2017. 5/2/17

Regulation 2600.105 (g) (1)

Immediately, on March 9, 2017 the Maintenance Director removed the lint from the Kenmore Dryer. The Maintenance Director then checked all lint traps in the other commercial dryers and in each neighborhood of the community. Reminder signs to empty lint traps were posted over each commercial dryer and for each dryer on April 24, 2017. The appropriate staff was re-trained by the Operations Specialist on April 24, 2017 regarding removal of lint prior to using the dryer. The Maintenance Director or designee will audit the dryers weekly for lint. The Executive Director will review the audit results for 2 months to determine if any further action is warranted.

Evidence- Staff training attendance log, Signage for dryers, audit tool

Completion Date: April 26, 2017 5/2/17

Regulation 2600.183 (b)

Immediately, the bottle of peroxide was discarded on March 9, 2017 by the Health and Wellness Director. The Operations Specialist re-trained the appropriate staff on April 25, 2017 regarding the community policy on medication storage. The Health and Wellness Director or designee will include in weekly medication cart audits monitoring for proper storage of medications. The Executive Director will review the audit results for 2 months to determine if any further action is warranted.

Evidence- Staff training attendance log 5/2/17

Completion Date: April 26, 2017

Regulation 2600.183 (d)

Immediately, the bottle of hydrogen peroxide and bottle of Nature's Bounty Vitamins D3-5000 were discarded March 9, 2017, by the Health and Wellness Director. Appropriate staff was retrained by the Health and Wellness Director on April 25, 2017 regarding the community policy on Medication Administration which included review of expiration dates prior to medication administration. The Resident Care Coordinator or designee will audit the medication administration records and medication carts weekly. The Health and Wellness Director will review these audits for compliance weekly for 2 months to verify if any further action is warranted.

Evidence- staff training attendance sheet
Completion date- April 26, 2017

5/2/17

Regulation 2600.185 (a)

Immediately, the medication was reordered from the pharmacy. Appropriate staff was retrained by the Health and Wellness Director on April 25, 2017 regarding the community policy on Medication Administration which included timely reorder of medications to assure there is an adequate supply for administration. The Resident Care Coordinator or designee will audit the medication administration records and medication carts weekly to assure all medications on the Medication Administration Record are available.. The Health and Wellness Director will review these audits for compliance weekly for 2 months to verify if any further action is warranted.

Evidence- staff training attendance sheet
Completion date- April 26, 2017

5/2/17

Regulation 2600.187 (d)

Appropriate staff was retrained by the Health and Wellness Director on April 25, 2017 regarding the community policy on Medication Administration which included notification of the physician if a medication is not administered. The Resident Care Coordinator or designee will audit the medication administration records and medication carts weekly to assure all medications on the Medication Administration Record are available and administration is documented according to community policy. The Health and Wellness Director will review these audits for compliance weekly for 2 months to verify if any further action is warranted.

Evidence- **staff training attendance sheet**
Completion date- April 26, 2017

5/2/17

Regulation 2600.225 (c)

Immediately, the resident support plan was updated to include the recent falls with strategies for further prevention of injuries. Note was also made to observe resident for decreased appetite and offering preferred foods. The Operations Specialist re-trained the appropriate staff regarding updating the assessment/ support plan on April 19, 2017 when a change of condition is identified. The Health and Wellness Director will review 2 support plans a week for 2 months to assure that any change in condition is addressed. The Executive Director or designee will review these audits for compliance weekly for 2 months to verify if any further action is warranted.

Evidence- staff training attendance sheet
Completion Date- ***April 19, 2017***

5/2/17

Regulation 2600.227 (d)

Support plan for resident #4 was updated to include the initiation of home health services. Operations Specialist re-trained the appropriate staff regarding updating the assessment/ support plan on April19, 2017 when a change of condition is identified and for inclusion of additional services. The Health and Wellness Director will review 2 support plans a week for 2 months to assure that any change in condition is addressed. The Executive Director or designee will review these audits for compliance weekly for 2 months to verify if any further action is warranted.

Evidence- staff training attendance sheet
Completion Date- April 19, 2017

5/2/17

Regulation 2600.234(a)

The appropriate staff was re-trained in the community policy regarding securing resident signature on the Personal Service Plan within 72 hours for residents admitted to the Secure Dementia Care Unit by the Operations Specialist on April 19, 2017. The Health and Wellness Director or designee will be review all admission Personal Service Plans/ RASP for verification

of resident signature in 72 hours of move-in. regarding the community policy on resident participation in the RASP/ support plan. The Resident Care Coordinator will review RASP/ support plan completion prior to placing in the medical record. The Health and Wellness Director or designee will audit the RASPS/ support plans for resident participation weekly as updated for 2 months to verify if further action is warranted. The Executive Director or designee will audit results of this audit for 2 months to verify if further action is warranted.

Evidence; staff training attendance sheet
Completion Date: April 19, 2017

5/2/17