



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

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

To operate LEHIGH COMMONS  
NAME OF FACILITY OR AGENCY

Located at 1680 SPRING CREEK ROAD, MACUNGIE, PA 18062  
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

\_\_\_\_\_  
ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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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 80  
(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 14**

Restrictions: \_\_\_\_\_

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 March 16, 2018 until March 16, 2019,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **222050**

Robert E. Robinson  
ISSUING OFFICER

Carolyn K. Ellison  
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.



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

MAR 19 2018

Mr. Thomas Howanitz  
Executive Director  
1680 Spring Creek Road Operations LLC  
1680 Spring Creek Road  
Macungie, Pennsylvania 18062

RE: Lehigh Commons  
License #: 222050

Dear Mr. Howanitz:

As a result of the Department of Human Services' (Department) annual licensing inspections on December 7, 2017 and March 9, 2018 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.

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](https://www.surveymonkey.com/r/BHSL_Inspection).

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,

A handwritten signature in black ink that reads "J. Rowe".

Jacqueline L. Rowe  
Director

Enclosure  
License Inspection Summary



Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

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

**2a. DESCRIPTION OF VIOLATION**  
 The batteries, in the Carbon Monoxide detector, located near the home's furnace were not dated as to when the batteries were installed; per the requirements of the Care Facility Carbon Monoxide Alarm 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.*

The batteries of the carbon monoxide detector were immediately dated. Compliance will be monitored by the Director of Maintenance or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*

*m*  
1/25/18

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/19/2017	03/28/2017
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

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

Date *1/4/18*

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

The above plan of correction is approved as of <u>1/25/18</u> (Date)	Plan of correction implementation status as of <u>1/25/18</u> (Date)
The above plan of correction was approved by <u>m</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.29a(b)(1) - A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met: A physician, who is not an employee or contractor of the home, has certified in writing that the resident is actively dying and may suffer bodily injury or a hastened death as a result of participation in a fire drill.

**2a. DESCRIPTION OF VIOLATION**

The home conducted a fire drill on 11-27-17 at 8:30 PM at that time Resident #1 a hospice patient was actively dying and the home did not evacuate Resident #1 to a fire safe area. The home did not have a physician's order stating that the resident would be harmed or it would hasten the resident's death if they participated in a fire drill.

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

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

The signed physician's order was immediately received and placed in the residents chart. A copy of the signed physician orders was given to the inspector's during the survey. Compliance will be monitored by the Executive Director or designee. A copy of the signed physician's order is attached.

*The administrator shall monitor and be responsible for ongoing compliance.*

*M  
1/25/18*

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)      Date

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The above plan of correction is approved as of 1/25/18  
 (Date)

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

Plan of correction implementation status as of 3/9/18  
1/25/18  
 (Date)

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

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.29a(b)(2) - A home that elects to serve one or more residents who receive hospice care and services in accordance with § 2600.29 is not required to evacuate a resident who is actively dying, during a fire drill, if all of the following are met: The resident, the resident's power of attorney for health care, the resident's legal guardian or the resident's health care representative has provided written informed consent that the person is not to evacuate in a fire drill.

**2a. DESCRIPTION OF VIOLATION**

The home conducted a fire drill on 11-27-17 at 8:30 PM, Resident #1 was actively dying and the home did not obtain written authorization from Resident #1's POA indicating that Resident #1 was not to evacuate during monthly practiced fire drills.

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

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The signed physician's order was immediately given to the POA and it was signed by the POA. A copy of the signed physician's order was placed in the residents chart. A copy of the signed physician's order was given to the inspector's during the survey. Compliance will be monitored by the Executive Director or designee. A copy of the signed physician's order is attached.

*The administrator shall monitor and be responsible for ongoing compliance*

*M*  
 11/25/18

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

*[Handwritten Signature]*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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*Thomas Hawa etc*

11/4/18

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 (Date)

Plan of correction implementation status as of 3/9/18  
11-25-18  
 (Date)

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

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

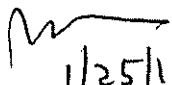
Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**  
 2600.29a(b)(5)(ii) - If the provisions of § 2600.29a(b)(4) are initiated, the informed staff person is to immediately practice a fire drill evacuation in accordance with the following: Reasonably simulate the level of effort required to move the resident and proceed to practice evacuation to the nearest unblocked exit or fire safe area. The simulation will include the number of staff persons that is required during an evacuation to safely move the resident.

**2a. DESCRIPTION OF VIOLATION**  
 Through interviewing the staff person assigned to Resident #1 on the date of the home's fire drill, it was determined that the staff did not simulate the evacuation procedure. Staff person reported that the Resident's bed had wheels and Resident #1 was prepared to be wheeled out of the facility's emergency exit. However, the simulation of the residents evacuation was not completed as required.

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

An in-service will be conducted with all center staff on properly evacuating all residents in the building during fire drills or when actual simulation will occur by January 19<sup>th</sup>, 2018.  
 Compliance will be monitored by the Director of Maintenance or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*  
  
 1/25/18

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)			Date
Thomas Howanitz			1/4/18
<b>DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!</b>			
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1/25/18 (Date)		3/9/18 1/25/18 (Date)	
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M (Initials)			

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**  
 2600.29a(b)(10) - The resident's assessment and support plan are to be kept current and specify the requirements of this section as it relates to the specific resident.

**2a. DESCRIPTION OF VIOLATION**  
 The home did not update Resident #1's RASP dated 04-21-17, indicating that the resident was actively dying and his/her death would be hastened or would cause suffering if they were to be evacuated to a fire safe area during a fire drill.

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

The resident RASP was updated on 12/7/17. A copy of the updated Resident # 1 RASP is attached. All residents on hospice will be evaluated periodically for their ability to be evacuated during fire drill. RASP's will be updated as necessary to reflect their ability to evacuate. Ongoing compliance will be monitored by the RCD or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*

*[Signature]*  
 1/25/18

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Thomasi Kowalik	1/4/18

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

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 (Date)

Plan of correction implementation status as of 3/9/18  
1/25/18  
 (Date)

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

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

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.54(a) - Direct care staff persons shall have the following qualifications:

- (1) Be 18 years of age or older, except as permitted in § 2600.54(b).
- (2) Have a high school diploma, GED diploma, or active registry status on the Pennsylvania nurse aide registry.
- (3) Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

**2a. DESCRIPTION OF VIOLATION**

Direct Care Staff Person A, date of hire 3-3-15, has a high school diploma from Poland. Staff Person A was retained beyond the 30 day provisional hiring period pending approval of the high school diploma from Poland.

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

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Direct care staff person "A" was moved to work as a housekeeper within the center. During the day of the survey a waiver was written, submitted and a copy of the waiver was given to the inspector's on the day of survey. The facility was advised by Jill Kachmar to contact an outside agency to authenticate the high school diploma of staff member "A". All appropriate paperwork was submitted to World Education Services on 12/13/17 and it is pending final review. Ongoing compliance will be monitored by the Business Office Manager or designee.

*1/29/18 Per conversation c Mr. Howanitz - Staff person "A" shall remain as a ancillary worker until all paperwork is verified & the waiver is either approved or denied - The administrator shall monitor and be responsible for ongoing compliance - M 1/29/18*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Thomas Howanitz</i>	<i>1/4/18</i>

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 (Date)

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 (Initials)

Plan of correction implementation status as of 1/29/18  
 (Date)

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

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:

- (1) Training that includes a demonstration of job duties, followed by supervised practice.
- (2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
- (3) Initial direct care staff person training to include the following:
  - (i) Safe management techniques.
  - (ii) ADLs and IADLs.
  - (iii) Personal hygiene.
  - (iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
  - (v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
  - (vi) Implementation of the initial assessment, annual assessment and support plan.
  - (vii) Nutrition, food handling and sanitation.
  - (viii) Recreation, socialization, community resources, social services and activities in the community.
  - (ix) Gerontology.
  - (x) Staff person supervision, if applicable.
  - (xi) Care and needs of residents with special emphasis on the residents being served in the home.
  - (xii) Safety management and hazard prevention.
  - (xiii) Universal precautions.
  - (xiv) The requirements of this chapter.
  - (xv) Infection control.
  - (xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

**2a. DESCRIPTION OF VIOLATION**

The personnel files for Direct Care Staff Members A, B, C, D, E, and F did not contain documentation that any of the fore-mentioned staff members have completed the Department approved Direct Care Training course. (Roman Numerals i - xvi)

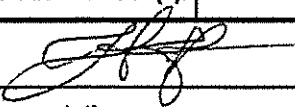
**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

All Direct Care Staff Members "A, B, C, D, E and F" were trained in 2017 <sup>as well as 2016</sup> as evidenced by the attached documentation. A copy of the 2018 in-service calendar with mandatory topics is attached. Ongoing compliance will be monitored by the Resident Care Director or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*

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

Signature of Legal Entity Representative (Required on EVERY Page)  11/25/18

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Thomas Howanice      Date 1/4/18

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

Plan of correction implementation status as of 1/25/18 (Date)

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

3/9/18

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.65(f) - Training topics for the annual training for direct care staff persons shall include the following:

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

**2a. DESCRIPTION OF VIOLATION**

Direct Care Staff Person A was missing the following mandatory elements for the 2016 annual training year: Medication Self-Administration; and, care for residents with mental illness and/or an intellectual disability.

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

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Direct care staff person "A" did receive Medication Self-Administration training on 8/1/17 and care for residents with mental illness and /or intellectual disability as required on 9/27/17. Both documents are attached. Refer to mandatory in-service calendar for 2018, see copy attached. Ongoing compliance will be monitored by the Business Office Manager or designee.

*Staff will also be trained in the elements of 2600 65(f) for the training year 2016.*

*The administrator shall monitor and be responsible for ongoing compliance. 1/25/18*


Repeat Violation: Yes  Date(s) of Previous Violation(s): 04/19/2017

Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Thomas Howansky* Date *1/4/18*

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The above plan of correction was approved by  (Initials)

Plan of correction implementation status as of 1/25/18 (Date) *m*

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

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**  
 2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:  
 (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.  
 (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.  
 (3) Resident rights.  
 (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).  
 (5) Falls and accident prevention.  
 (6) New population groups that are being served at the home that were not previously served, if applicable.

**2a. DESCRIPTION OF VIOLATION**  
 Direct Care Staff Person A did not receive training in fire safety 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.

Direct care staff person "A" did receive fire safety training as required on 10/11/17. Signed document is attached. Refer to mandatory in-service calendar for 2018, see copy attached. Ongoing compliance will be monitored by the Business Office Manager or designee.

• Staff will also be trained in the elements of 2600.65(g) for the training year 2016.  
 • The administrator shall monitor and be responsible for ongoing compliance. M 11/25/18

Repeat Violation: Yes      Date(s) of Previous Violation(s): 04/19/2017

Signature of Legal Entity Representative  
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Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page)      Date 11/4/18

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 (Initials)

Plan of correction implementation status as of 11/25/18  
 (Date)

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- Not Implemented

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**  
 2600.81(b) - Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**2a. DESCRIPTION OF VIOLATION**

An enabler bar, measuring 19 inches x 17 inches, was uncovered and attached to the bed in room #206b. The enabler bar presents a possible risk of serious injury to the head, arms or legs.

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

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

Immediately the enabler bar was removed and a new enabler was installed by therapy with cover. Rooms will be audited periodically to ensure that no unsafe equipment is being utilized. An in-service will be conducted with all center staff on the importance of assuring all enabler bars are properly covered to maintain resident's safety by January 19<sup>th</sup>, 2018. Ongoing compliance will be monitored by the Resident Care Director or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*

*[Signature]*  
 1/25/18

Repeat Violation: No	Date(s) of Previous Violation(s):			
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Thomas Howanitz* Date *1/4/18*

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Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

**2a. DESCRIPTION OF VIOLATION**

The home conducted a fire drill on 11-27-17 at 8:30am and documented that 62 residents were evacuated into the home's fire safe areas. However, only 61 residents were evacuated into the home's fire safe areas, Resident #1 was not evacuated.

**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.*

On 11/26/17 at 8:30 pm the fire drill was performed as noted on the copy of the fire drill record provided to the inspectors on the day of survey, see copy attached. 66 residents were evacuated from the building. Documentation in the future will reflect the actual number of residents evacuated. Ongoing compliance will be monitored by the Executive Director or designee.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page)

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

Thomas Howanitz

Date 1/4/18

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11/25/18  
 (Date)

Plan of correction implementation status as of

3/9/18  
 1/25/18  
 (Date)

The above plan of correction was approved by

(Initials)

- Fully Implemented
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- Not Implemented

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- (10) Duration of therapy, if applicable.
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

**2a. DESCRIPTION OF VIOLATION**

Resident #2's MAR was not initialed after the medication, Atorvastatin 10 mg., was administered at 5:00pm on 12/6/17.

**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.*

All Med Techs will be in serviced on the timelines and importance of accuracy in documentation by January 19<sup>th</sup>, 2018. Ongoing compliance will be monitored for completeness by Resident Care Director or designee.

*The administrator shall monitor and be responsible for ongoing compliance. m, 1/25/18.*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)



Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Thomas Howanitz	1/4/18

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

The above plan of correction is approved as of 1/25/18  
 (Date)

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

Plan of correction implementation status as of 1/25/18  
 (Date)

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

3/9/18

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
PCH Name: LEHIGH COMMONS

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

2a. DESCRIPTION OF VIOLATION  
Resident #3's Lorazepam 0.5mg and Oxycod/Acetaminophen 5/325mg was initialed the medications were given on 11-28-17 at 6:00pm. Resident #3 was in the hospital at that time.

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.

During a review of the Narcotic Book, during survey it was noted that on 11/29/17 at 6:00 pm that the date of 11/28/17 was written in error as verified by the correct narcotic count. All Med Techs will be in serviced on the timelines and importance of accuracy in documentation by January 19<sup>th</sup>, 2018. Ongoing compliance will be monitored for completeness by Resident Care Director or designee.

The administrator shall monitor and be responsible for ongoing compliance.  
m 1/25/18

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)      Date 1/4/18

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

The above plan of correction is approved as of 1/25/18 (Date)

Plan of correction implementation status as of 3/9/18 / 1/25/18 (Date)

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

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

Violation Report: 22205 - 12/07/2017 - Yellenic, Cindy  
 PCH Name: LEHIGH COMMONS

**1. REGULATION 55 Pa.Code §2600**  
 2600.233(c) - If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

**2a. DESCRIPTION OF VIOLATION**  
 The home did not have the directions for the use of the home's magnetic lock door system posted in a conspicuous area, near the exterior gate located in the Secure Dementia Care Units's outdoor courtyard,

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

Immediately the directions for the use of the home's magnetic lock door system were posted in a conspicuous area near the exterior gate. See attached photograph. Ongoing compliance will be monitored for completeness by Director of Maintenance or designee.

*The administrator shall monitor and be responsible for ongoing compliance.*  
*M*  
*1/25/18*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
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**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of 1/25/18  
 (Date)

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

Plan of correction implementation status as of 3/9/18  
1/25/18  
 (Date)

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