pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAY 2 9 2018

Mr. Bruce G. Baron, Esquire
Capozzi Adler, P.C. Attoneys at Law
2933 North Front Street
Harrisburg, Pennsylvania 17110

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

Dear Mr. Baron,

This is to acknowledge receipt of your request to appeal the Department's decision to REVOKE the license for Senior Commons at Powder Mill. Your request has been forwarded to the Department of Human Services, Bureau of Hearings and Appeals. You will be contacted regarding the date and time of the hearing.

Sincerely,

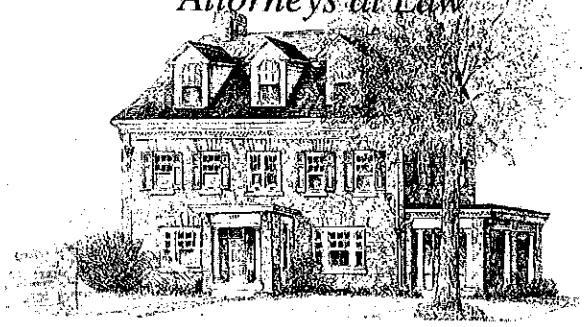
Jacqueline L. Rowe
Director

cc: Mary Lavery, Office of General Counsel

Louis J. Capozzi, Jr., Esquire*
Daniel K. Natirboff, Esquire
Donald R. Reavey, Esquire
Craig I. Adler, Esquire**
Andrew R. Eisemann, Esquire***
Glenn A. Parno, Esquire**
Bruce G. Baron, Esquire
Brandon S. Williams, Esquire
Nicholas J. Luciano, Esquire
Joseph J. Gentile, Esquire****
Garrett Rothman, Esquire, of Counsel
Timothy Ziegler, Sr. Reimb. Analyst
Karen L. Fisher, Paralegal
Linda Gussler, Paralegal
Kelly A. Galski, Paralegal
*(Licensed in PA, NJ and MD)
**(Licensed in PA and NJ)
***(Licensed in PA and NY)
****(Licensed in PA, NJ and CA)

Capozzi Adler, P.C.

Attorneys at Law



Primary Office:
2933 North Front Street
Harrisburg, PA 17110
Telephone: (717) 233-4101
Facsimile: (717) 233-4103
www.capozziadler.com

Mid-Penn Abstract Company
355 N. 21st Street, Suite 205
Camp Hill, PA 17011
Telephone: (717) 234-3289
Facsimile: (717) 234-1670

May 25, 2018

RECEIVED

MAY 25 2018

Human Services Licensing

Shivani Patel, Enforcement Manager
Human Services Licensing
Pennsylvania Department of Human Services
Room 631, Health & Welfare Building
625 Forster Street
Harrisburg, PA 17120

BY HAND DELIVERY

5/25/18

RE: Request for Appeal & Request for Clarification of Notice
Notice of Intent to Revoke License Dated May 21, 2018
Senior Commons at Powder Mill (PCH License # 332100)
Our Matter No.

Dear Enforcement Manager:

Our Firm represents the Licensee, GAHC3 York PA ALF TRS SUB, LLC d/b/a Senior Commons at Powder Mill, 1775 Powder Mill Road, York, PA 17403. On behalf of our client, the Licensee, and pursuant to the letter dated May 21, 2018 from Jacqueline L. Rowe, Director, Bureau of Human Services Licensing (a copy of which is attached hereto) ("the May 21, 2018 Letter"), we are filing this written request for an appeal pursuant to 1 Pa. Code Chapters 31-35 and 55 Pa. Code §§ 20.81-20.82. Please forward this request for an appeal to the Bureau of Hearings and Appeals to schedule a hearing in this matter.

Our client disputes the basis for the May 21, 2018 Letter on the basis that it is arbitrary and capricious and an abuse of the Bureau's discretion given the facts stated. Our client requests that the proposed revocation be withdrawn and that, instead, a Provisional I license be issued.

This letter also requests your confirmation that the admissions to the facility after the date of the May 21, 2018 Letter but prior to the Licensee's receipt of the May 21, 2018 Letter's notice of the ban on admission are not violations of or affected by the ban on admissions imposed by the May 21, 2018 Letter. My client advised today that they received verbal confirmation of this from the Bureau staff.

Very truly yours,

Bruce G. Baron, Esquire

Attachment.
cc: Kevin M. McCollum
Greg Bobka, Esq.

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 2 1 2018

Mr. Kevin M. McCollum,
Member
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 Mr. McCollum:

As a result of the Department's Bureau of Human Services Licensing annual inspections on November 20, 2017, November 21, 2017, November 27, 2017, December 8, 2017, January 31, 2018, February 1, 2018, February 2, 2018, February 20, 2018, April 4, 2018, April 5, 2018, and April 6, 2018 of the above facility, the violations specified on the enclosed Licensing Inspection Summary were found.

As a result of violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes), the Department is REVOKING your license to operate the above facility. The Department's decision to revoke your license is based on your failure to comply with the Department's regulations and gross incompetence, negligence and misconduct in operating the facility and is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa.Code § 20.71(a)(2);(6) (relating to conditions for denial, nonrenewal or revocation).

In accordance with 55 Pa.Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

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

55 Pa.Code Chapter 2600 Section no.	Class of Violation	Census at Inspection X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
16c	III	109	$3		$327	15 calendar days from mailing date of this letter
17	III	109	$3		$327	15 calendar days from mailing date of this letter
187d	II	109	$5		$545	5 calendar days from mailing date of this letter

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

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

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

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

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

The enclosed Licensing Inspection Summary specifies plans of correction and dates by which corrections must be made. If you choose to appeal, this plan of correction must be followed during your operation pending your appeal.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
Licensing Inspection Summary

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

PCH Name: SENIOR COMMONS AT POWDER MILL | License Number: 33210

Address: 1775 POWDER MILL ROAD, YORK, PA 17403 | County: York

Administrator: David Paveletz | 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
07/23/2001
L&I

Staffing Hours

Resident Support: 0 | Total Daily Staff: 136 | Waking Staff: 102

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

Reason(s) for Inspection(s)

Complaint

On-Site Inspections Dates and Department Representatives On-Site

11/20/2017: Springs, Israel; Gillespie, Denise
11/21/2017: Springs, Israel; Gillespie, Denise
11/27/2017: Springs, Israel; Gillespie, Denise
12/08/2017: Swanger, Brett; Heemer, Laura

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: 166

Number of Residents Served: 105

Secured Dementia Care Unit in Home: Yes

Area: SDU

Secured Dementia Unit Capacity, If Applicable: 28

Number of Residents Served in Secured Dementia Care Unit, If applicable: 23

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 12

Number of Residents who:

Receive Supplemental Security Income: 0

Are 80 Years of Age or Older: 86

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 31

Have a Physical Disability: 0

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 2600.16 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 10/27/17 and 10/28/17, a staff person of the home administered morphine to Resident #1 from the comfort pack prescribed for Resident #2, because the morphine prescribed for Resident #1 was not present in the home. The home failed to report this medication error to the Department.

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

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

Immediate Correction: Prior practice was to receive comfort packs for Hospice residents. Current practice is not to accept comfort packs for Hospice residents. Med-techs will be educated by the Resident Care Director (RCD) on the regulation 2600.16(c), and the need to report any medication error to the Department. Senior Commons has hired a LPN on 12/26/17 to assist with support of the med-techs on 3-11 and 11-7 shifts.

When: Will have the education completed by 1/5/18 and on-going.

How: Education will be completed and documented by each med-tech and the medication error policy by 1-5-18.

On-going: RCD will receive all incident reports with proof of fax times. She will monitor that all initial reports are faxed on time. A copy of the report is then given to the Executive Director for over-sight, follow-up, monitoring and storage. The RCD/Designee will conduct weekly audits of the EMR to review all reportable incidents have been reported in a timely manner. The QA audits will be discussed with the QA committee quarterly.

Repeat Violation: yes	Date(s) of Previous Violation(s):	7/27/17	4/25/17	

Signature of Legal Entity Representative (Required on EVERY Page): David Pavelitz

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): David Pavelitz, Executive Director | Date: 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of _____ (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 10/31/17 at approximately 11:15 pm, while being assisted to his/her bedroom by Staff Member B, Resident #3 fell to the floor. The resident struck his/her head and face on the floor and was described by staff members as being "asleep" after the fall and unresponsive to staff interaction. Staff Members B and C picked the resident off the floor, transported the resident to his/her bedroom, and placed the unresponsive resident into bed. At approximately 5:00am on 11/1/17, while performing a check on the resident, Staff Member B observed bruising around Resident #3's right eye and the resident was still unresponsive. At approximately 6:35am, Staff Member D assessed Resident #3's condition after being told of the resident's fall and black eye. The resident was sent to the hospital emergency room via ambulance and the resident was found to have intracranial bleeding. On [redacted]17, Resident #3 died, the death certificate listing "Complications Related to Fall" as the immediate cause of death.
The home failed to provide the essential services necessary to address Resident #3's fall and loss of consciousness in a timely manner.

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.

Immediate Correction: Resident 3 no longer resides at Senior Commons. The med-tech was educated on the need to contact the Resident Care Director with any fall, and the need to transfer any resident who has hit their head to the Emergency Room for evaluation. Med-tech on sight was educated and she now is not a current employee of Senior Commons. All Med-techs were educated in November 2017 on the protocol of potential head injuries. They were educated that any resident who has fallen and hit their head be sent out to the Emergency Room for evaluation. They need to notify the Resident Care Director/Designee with any falls as they occur. Also, that they need to notify the responsible party and physician. Senior Commons has hired a LPN to assist with the supervision of the med-tech's for overlap of 3-11 and 11-7 shifts. Also, we are hiring a designated Memory Care Director.

When: All med-techs were educated on the fall protocol in November 2017. The LPN was hired on 12-26-2017.

How: The med-techs were educated on the fall protocol by the Resident Care Director in November 2017.

On-Going: All falls will be QA by the Resident Care Director/Designee to ensure that protocols have been followed. Incident reports will be forwarded to the Executive Director for further review. QA audits will be discussed at the quarterly QA meeting.

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): David Pavelitz Executive Director — Date: 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION

On 12/8/17, an unclean bedsheet was located on the top of the common use microwave next to the washer/dryer unit in the 400 hallway kichenette/laundry.

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.

Immediate Correction: The unclean bedsheet was removed from the common area on 12/8/17. Staff will be educated on the importance of monitoring the environment for sanitary conditions and ensuring they maintain sanitary conditions by 1-5-18.

When: Education on sanitary conditions to be completed by 1/5/18.

How. Education to include if they notice any unclean items in the common areas to ensure that it is placed in the proper bin or discarded.

On-Going: Executive Director/Designee will QA the common areas daily for unsanitary conditions. Results will be reviewed quarterly with the QA committee.

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) David Lueckle Executive Director Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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 10/20/17, seven Lorazepam 0.5 mg tablets originally prescribed for Resident #4 (discontinued on 8/18/17), and eight 5mg/0.25 ml Morphine syringes from the comfort pack of Resident #2 (died [redacted]17) were located in Staff Member A's office desk drawers.

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.

Immediate Correction: Employee A was provided discipline for keeping residents medications in the facility after the medication was discontinued. Resident 4's and Resident 2's medications were destroyed on 11/20/2017. Education was provided in November to the RCD and the med techs and Senior Common's policy Medication Disposal.

When: Education was provided in November 2017 and on-going.

How: Med techs were educated on Senior Common's Policy of medication disposal.

On-going: Resident Care Director will QA all medication orders that were discontinued by using the discontinued medication report to ensure that the medications were disposed of according to policy. QA results will be reviewed quarterly with the QA committee.

The executive director will perform weekly checks of the office space used by Staff Member A to ensure compliance with the regulation. The checks will be made on random days of the weeks and at random times of the day.

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) David Parelski Executive Director Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

Violation Report: 33210 - 11/20/2017 - Springs, Israel
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600
2600.184(b) - If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

2a. DESCRIPTION OF VIOLATION
A cloth shopping bag of unlabeled medications was located on the floor next to the desk of Staff Member A. The medications in this bag were: Nasal Spray 3 fl oz; Mucus Relief 400 mg; Aspirin 325 mg; Centrum Silver; Aleve 220 mg; Potassium Gluconate 500 mg; Imodium AD 2 mg; 2 bottles of Magnesium 500 mg; Acidophilous Probiotics; Melatonin 5 mg.

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.

Immediate Correction: Employee A was provided discipline action for medications in the facility without any resident's name on them. Those medications were destroyed on 11/20/2017. Resident Care Director and med-techs were educated on Senior Commons Policy and Procedures: Medication and disposal part 4 in November 2017.

When: Education provided in November 2017 for the med techs and Employee A

How: Education was provided in November 2017on Senior Commons Policy and Procedure on medication and storage part 4 which states each resident's medications are maintained in separate containers with their names.

On-Going: Executive Director/Designee will randomly QA med carts to ensure that the medications have the resident name on it. Results will be reviewed quarterly with the QA committee.

The executive director will perform weekly checks of the office space used by Staff Member A to ensure, compliance with the regulation. The checks will be made on random days of the weeks and at random times of the day.

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

Signature of Legal Entity Representative (Required on EVERY Page): David Lasky

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): David Lasky Executive Director

Date: 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.186(b) - Prescription medications shall be used only by the resident for whom the prescription was prescribed.

2a. DESCRIPTION OF VIOLATION

On 10/27/17 and 10/28/17, Staff Member A instructed the home's medication administration staff to administer a syringe of morphine 5mg/0.25 ml prescribed for the deceased Resident #2 to Resident #1 because Resident #1's prescribed morphine was not present 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.

Immediate Correction: Employee A was provided discipline action for instructing a staff member to use a resident's medication for another resident. All Med-tech's and LPN's will be educated on 2600.186(b) by 1/5/18.

When: all Med-techs and LPNs will be educated that prescribed medications shall be used only by the resident for whom the prescription was prescribed.

How: Education will be documented and completed for each med tech and LPN by 1/5/18

On-going: Resident Care Director/Designee will QA 5 residents weekly to ensure that residents are given the medications that they are prescribed. QA results to be reviewed quarterly with the QA committee.

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) Daniel Pavlek Executive Director

Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.188(b) - A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

2a. DESCRIPTION OF VIOLATION

On 10/27/17 and 10/28/17, a staff person of the home administered morphine to Resident #1 from the comfort pack prescribed for deceased Resident #2, because the morphine prescribed for Resident #1 was not present in the home. The home failed to report this medication error to the prescriber.

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.

Immediate Correction: Both resident 1 and 2 are no longer residing at Senior Commons. Med-techs and LPNs will be educated by 1-5-18 on the need to notify the resident or the resident's designated party and the prescriber of any medication errors.

When: Education to be completed by 1/5/18 to all med-techs and LPNs.

How: Education to be completed by 1/5/18 on the regulation of reporting mediation errors to the resident/resident's designated party and prescriber. And the Senior Common's policy on medication errors.

On-Going: Resident Care Director/Designee will QA all medication errors to ensure that the resident/resident's designated party and prescriber were notified of the error. Results to be reviewed quarterly to the QA committee.

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	

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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

Subsequent to the assessment completed for Resident #5 on 2/24/17, the resident experienced a marked decline in strength, steadiness, and ability to ambulate. The resident had a fall on 9/17/17 that resulted in physical therapy, occupational therapy, home health services, and a wheelchair for the resident. The home did not reassess the needs of the resident as related to this significant change in abilities.

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.

Immediate Correction: Resident 5 no longer resides at Senior Commons. Resident Care Director/Designee will audit electronic medical records daily to ensure all changes are updated on the RASP.

When: Resident Care Director/designee will be educated on the importance of the reviewing all resident's electronic medical record to ensure all significant changes are updated. on the RASP by 1/5/2018.

How: Resident Care Director and Resident Care Coordinator will review electronic medical record daily to capture any significant changes with residents changes an updated on the RASP

On-Going: Resident Care Director/Designee will QA 5 resident charts weekly to ensure that significant changes have been updated accordingly in the RASP. Results to be reviewed quarterly by the QA committee.

Repeat Violation: yes	Date(s) of Previous Violation(s):	4/25/17		

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Executive Director Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2800

2800.227(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 #5 had physical therapy services start on 9/26/17, occupational therapy services start on 9/27/17, home health services start on 10/20/17, and on 11/15/17 the resident was provided a wheelchair for assistance with ambulation. The most recent support plan, dated 2/24/17, was not updated to reflect any of these additional services.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Immediate Concern: Resident 5 no longer resides at Senior Commons. Resident Care Director/designee will review all current residents to ensure that their RASP is updated with all outside services and any assistance that a current resident receives with medical, dental, vision, hearing, mental health or other behavioral care service.

When: The Resident Care Director/designee will complete the current resident's charts by 1/5/18 for updates with any outside services and any assistance that current residents receive with medical, dental, vision, hearing, mental health, or other behavioral care services.

How: Resident Care Director/designee will review all current resident's RASP to ensure that they include all outside services and all services the residents receive with medial, health, or other behavioral care services.

On-Going: Resident Care Director will review 5 resident charts weekly to ensure that all outside services are updated and that all services that residents receive with medical, dental, vision, hearing, mental health, or other behavioral concerns are update on the RASP. Results will be reviewed quarterly with the QA committee.

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

Printed Name and Title: Daniel Lucente, Executive Director — Date: 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600
2600.234(d) - The support plan shall be revised at least annually and as the resident's condition changes.

2a. DESCRIPTION OF VIOLATION
Resident #3's most current support plan, completed on 8/17/17, documents that the resident exhibits no problems with aggression, irritability, and agitation. Subsequent to this support plan, the resident started regularly displaying physically aggressive and exit seeking behaviors, including an episode on 9/4/17 where the resident was pushing on all doors in the unit and punched a staff member in the face. The home did not update the resident's support plan to identify these behaviors and the supports needed.

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.

Immediate Correction: Resident 3 does not reside at Senior Commons. The resident Care Director/designee will audit all current resident charts to ensure the resident's changes in condition are revised on the RASP.

When: Resident Care Director/designee will go through electronic medical record and update their RASP with any changes in condition by 1/5/18.

How: Resident Care Director/designee will go through electronic medical record to ensure that the resident's that have had change in condition are reflected on the RASP.

On-Going: Resident Care Director/Designee will QA 5 resident charts weekly to ensure changes in condition are updated on the RASP. Results will be reviewed quarterly with the QA committee.

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	

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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

PCH Name: SENIOR COMMONS AT POWDER MILL

Address: 1775 POWDER MILL ROAD, YORK, PA 17403 | License Number: 33210

Administrator: David Paveletz | County: York

Legal Entity Name: GAHC3 YORK PA ALF TRS SUB LLC | Region: CENTRAL

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

Certificate(s) of Occupancy

C-2 LP
07/23/2001
Labor and Industry

Staffing Hours

Resident Support: 0 | Total Daily Staff: 135 | Waking Staff: 101

Type of Inspection: Interim - POC | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)

Interim, Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site

01/31/2018: Heemer, Laura; Gillespie, Denise
02/01/2018: Heemer, Laura; Gillespie, Denise
02/02/2018: Heemer, Laura; Gillespie, Denise
02/20/2018: Heemer, Laura

Off-Site Inspection Dates and Inspectors, if Applicable

02/09/2018: Heemer, Laura
02/12/2018: Heemer, Laura

Other Details

Partial or Full Triggers:

Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 166

Number of Residents Served: 105

Secured Dementia Care Unit in Home: Yes

Area: Arlington and Rosewood Courts

Secured Dementia Unit Capacity, if Applicable: 28

Number of Residents Served in Secured Dementia Care Unit, if applicable: 21

Number of Current Hospice Residents: 6

Number of Hospice Residents in past year: 12

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 104

Have Mental Illness: 6

Have an Intellectual Disability: 1

Have a Mobility Need: 30

Have a Physical Disability: 1

David Paveletz
2/28/18

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 2/1/2018 at approximately 2 pm, the 400 Hallway computer on the medication cart, in which electronic Medication Administration Records are stored, was open and accessible for anyone to access confidential resident information.

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.

Immediate Correction: The med tech that was on the hall was educated on ensuring that no resident information is displayed on the computer screen when she is not near the computer. By clicking on the sun glasses.

When: All med techs will be educated by 2-28-18.

How: All med techs will be educated on the importance to ensure that no resident information is displayed on the computer screen when they are not near the computer.

On-Going: RCD/Designee will conduct weekly audits of the computer screens to ensure that no resident information is displayed when staff is not at the computer. QA results to be reviewed with QA committee.

Repeat Violation: Yes	Date(s) of Previous Violation(s): 4/25/17		
Signature of Legal Entity Representative (Required on EVERY Page)	David Pawelec		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	David Pawelec Executive Director	Date	2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION

On 01/31/2018, there was a wooden chair with a wicker seat located in the lounge at the end of the 600 Hallway. The chair had a white and green fabric covered cushion tied onto the seat. The surface of this cushion had a brown stain covering approximately half of its top surface.

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.

Immediate correction: The cushion was thrown out on 1-31-18. Will add monitoring to monitor furniture and equipment to be in good repair, clean and free of hazards to the daily QA of unsanitary conditions.

When: Education on ensuring furniture and equipment must be in good repair, clean and free of hazards will be completed by 2-28-2018.

How: Education will include that if they notice any furniture or equipment to not be in good repair or is they see nay hazards to add to the tels report so we are notified of the concern.

On-Going: Executive Director/Designee will QA the furniture and equipment daily to ensure that it is in good repair and free of hazards and stains. Results will be reviewed with the QA committee.

Repeat Violation: No	Date(s) of Previous Violation(s):
Signature of Legal Entity Representative (Required on EVERY Page)	David Pauley
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	David Pauley Executive Director
Date	2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.182(b) - Prescription medication that is not self-administered by a resident shall be administered by one of the following:

(1) A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.

(2) A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.

(3) A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.

(4) A staff person who has completed the medication administration training as specified in § 2600.190 for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

2a. DESCRIPTION OF VIOLATION

On the following dates, Staff Person A administered medications to Resident# 1 and other residents of the home:
1/12/18 at 8am and 12 am
1/14/18 at 8 am and 12 am
1/16/18 at 8 am and 12 am
1/20/18 at 8 am and 12 am
1/21/18 at 8 am and 12 am
1/22/18 at 8 am and 12 am

Staff person A is not a medical professional approved to administer medications and has not completed the Department's medication administration training.

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

Immediate Correction: Staff person A is no longer an employee of Senior Commons at Powder Mill.

When: RCD will be educated that only one of the following could administer medications if not self-administered by the resident by 2-28-18.

1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse, or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in 2600.190 for the administration of oral; tropical; eye, nose, and ear prescription medications; insulin and epinephrine injections for insect bites and other allergies.

How: The RCD is aware that if a staff member who has completed medication administration training as specified in 2600.190 can not show evidence of this completion they will not be able to administer medications until they show proof of the completion of the training.

On-Going: The RCD will QA all current med techs files to ensure that they meet the requirements to administer medications. The RCD will QA any new hired med techs files to ensure that they meet the requirements of administering medications according to 2600.182(b). Results will be shared with the QA committee.

Signature of Legal Entity Representative (Required on EVERY Page) David Powell

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) David Powell Executive D.O. Date 2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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 failed to fully implement its procedures for the safe storage, access, distribution and use of medications on 1/22/2018 when a controlled substance was unaccounted for. The home conducted drug tests of employees, but did not make a police report, notify the Department, and the local Area Agency on Aging as directed in the home's Medication Storage and Disposal Policy.

The home's procedures require that two staff members perform narcotics counts in tandem and both sign off on a log sheet that the counts occurred during each change of shift. The home failed to implement these procedures when only one staff member conducted the narcotic count on the following days:

On the 400 Medication Cart:
1/7/18 on the 7am-3pm-11pm shift and the 11pm-7 am shift
1/11/18 on the 11pm- 7 am shift
1/12/18 on the 7 am-3 pm shift and the 3pm-11pm shift

On the 500 Hall Medication Cart:
1/14/18 on the 7 am- 3pm shift

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.

Immediate Correction: All med techs will be educated on the Policy of medication storage and disposal. The training will be emphasized on the need for the narcotics to be counted by 2 staff members on the beginning and the end of each shift. If the count is off then the RCD/Designee needs to be notified as soon as possible.

When: All med techs will be educated on medication storage and disposal by 2-28-18.

How: Education will include the importance that all narcotics need to be counted by 2 staff members at the beginning and end of each shift. If the count is off the RCD/Designee needs to be notified as soon as possible.

On-Going: The RCD/Designee will QA All narcotic sheets daily to ensure that all narcotics were counted by 2 staff members at the beginning and end of each shift.

Repeat Violation: Yes	Date(s) of Previous Violation(s): 7/27/17		

Signature of Legal Entity Representative (Required on EVERY Page) Daniel Pavelitz

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Daniel Pavelitz Exec. Dir. Date 2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

The home failed to follow the directions of the prescriber when the Morphine Sul Sol 100/5ML, 0.25 ML pre-filled syringes prescribed to Resident# 2 were not administered as ordered every 6 hours. Staff members initialled the Medication Administration Record (MAR) indicating the medication had been administerered, however the home's Narcotics Administration Record sheet shows that the medication was not administered by the staff person and the actual narcotic count corroborates that the administration was not performed. The failure to provide administration of this medication occurred on the following dates and times:

Jan 7, 2018 at 12 pm by Staff Person B
Jan 8, 2018 at 12 am and 6 am by Staff Person B
Jan 9, 2018 at 6 am by staff Person B
Jan 11, 2018 at 12 pm by Staff Person B
Jan 13 at 12 pm by Staff Person B

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.

Immediate Correction: Resident 2 is no longer a resident at Senior Commons of Powder Mill. Staff member B will be educated on the importance of documenting the reason why a medication was not given.

When: All med techs will be educated on the policy to document the reason why a medication was not administered (exception) by 2-28-18.

How: RCD/Designee will educate the med techs to document the reason why a medication was not administered and the need to notify the physician.

On-Going: The RCD will QA all medications that were not given to ensure that the reason for the medication not given is documented and that the physician was notified.

Repeat Violation: Yes	Date(s) of Previous Violation(s): 7/27/17		

Signature of Legal Entity Representative (Required on EVERY Page) David Purely

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) David Purely Jr. Exec. Dir. Date 2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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 #1 receives physical therapy. The resident's most recent support plan, dated 3/17/17, does not document the need for this service and identify the provider of this service.

Identifying information for Resident #1's cardiologist is not documented on the most recent support plan, dated 3/17/17.

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.

Immediate Concern: Resident 1 is currently not at the facility. RCD/Designee will review all current residents to ensure that their rasp is updated with all outside services and any assistance that a current resident receives with medical, dental, vision, hearing, mental health or other behavioral care services.

When: The Resident Care Director/Designee will complete the current resident's charts by 2-28-18 for updates with any outside services and any assistance that current residents receive with medical, dental, vision, mental health or other behavioral services.

How: Resident Care Director/designee will review all current resident's RASP to ensure that they include all outside services and all services the residents receive with medical, health, or other behavioral care services.

On-going: Resident Care Director/Designee will review 5 resident charts weekly to ensure that all outside services are updated and that residents receive with medical, dental, vision, hearing, mental health, or other behavioral concerns are updated on the RASP. Results will be reviewed with the QA committee.

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) Daniel Lewis Jr. Exec. Dir. Date 2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600
2600.234(b) - The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

2a. DESCRIPTION OF VIOLATION
The resident notes for Resident #3document that the resident is often very agitated in regards to bathing: and that Resident 3 sleeps in regular clothing not sleep wear and becomes agitated and refuses when asked to change clothes.
The most recent support plan, completed 1/4/2018, documents that Resident #3 has no problems related to Irritability and Agitation, and does not address the behaviors documented in the notes that can create agitation in the resident.

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.

Immediate Correction: Resident 3's RASP was updated that she becomes agitated with bathing. Also, that she sleeps in regular clothing as she becomes agitated when asked to change clothes.

When: RCD/Designee will go through medical records to ensure that residents physical, medical, social, cognitive and safety needs are updated on the RASP.

How: RCD/Designee will review the resident's electronic medical record to ensure that the residents have their physical, medical, social, cognitive and safety needs updated on the RASP.

On-Going: RCD/Designee will QA 5 resident charts weekly to ensure that the resident's physical, medical, social, cognitive and safety needs are updated on RASP. Results will be reviewed with the QA committee.

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	David Pavlik			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	David Pavlik Exec. Dir.		Date	2/28/18

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

The above plan of correction is approved as of 3/1/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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

PCH Name: SENIOR COMMONS AT POWDER MILL

License Number: 33210

Address: 1775 POWDER MILL ROAD, YORK, PA 17403

County: York

Administrator: David Paveletz

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
07/23/2001
L & I

Staffing Hours

Resident Support: 0

Total Daily Staff: 144

Waking Staff: 108

Type of Inspection: Full

BHA Docket Number:

Notice: Unannounced

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

04/04/2018: Gillespie, Denise; Springs, Israel
04/05/2018: Gillespie, Denise; Springs, Israel
04/06/2018: Gillespie, Denise; Springs, Israel

Off-Site Inspection Dates and Inspectors, If Applicable

Other Details

Partial or Full Triggers: N/A

Random Indicators: N/A

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 166

Number of Residents Served: 109

Secured Dementia Care Unit in Home: Yes

Area: Rosewood Court and Arlington Court

Secured Dementia Unit Capacity, If Applicable: 28

Number of Residents Served in Secured Dementia Care Unit, If applicable: 25

Number of Current Hospice Residents: 4

Number of Hospice Residents in past year: 42

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 109

Have Mental Illness: 6

Have an Intellectual Disability: 1

Have a Mobility Need: 36

Have a Physical Disability: 17

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 1/18/18, the home's administration was made aware of an incident where Resident # 1's bedroom door handle was tied to an adjacent hand rail to restrict the resident's ability to leave the bedroom. The home did not report this incident to the Department until 4/6/18.

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.

Immediate Correction: The facility did report this incident to the Department on 4-16-18. Med-techs, Memory Care Director, Resident Care Coordinator will be educated on regulation 2600.16(c) to ensure that they are aware of reportable incidents. The Executive Director/Designee is monitoring all incidents to ensure that they are reported to the Department if they qualify under regulation 2600.16(c).

When: Will have the education completed by 5-7-18.

How: The Resident Care Director will ensure that Med-techs, Memory Care Director, Resident Care Coordinator are educated on the regulation 2600.16(c).

On-going: The Executive Director/Designee will review all incident reports to ensure, if they are reportable events under 2600.16(c), they are reported to the Department. Audits will be reviewed with the quality assurance committee.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/25/2017		

Signature of Legal Entity Representative (Required on EVERY Page): David Pawelko

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): David Pawelko, Executive Director | Date: 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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 4/4/18 at 10:45 A.M., a binder containing confidential information regarding the prescribed hospice services for residents who are receiving Caring Hospice Services was located at the nursing station across from resident bedroom #504. The binder was not stored in a locked area and the area was not occupied by a staff memebr of the home at this time.

On 4/4/18 at 10:50 A.M. a folder containing confidential information regard the care assignment sheets and diagnoses for the residents in the 500-600 hall was located in the nursing station across from resident bedroom # 517. The folder was not stored in a locked area and the area was not occupied by a staff memebr of the home at this 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.

Immediate Correction: On 4-4-18 the facility removed the binder from the nursing station across from room #504 and had it locked in a drawer. On 4-4-18 the folder containing the assignment sheets for the residents located in the nursing station across from resident room #517 was removed and stored in a locked drawer. All nursing staff will be educated that Hospice information and assignment sheets will be available with folders behind the clean linen doors which are locked.

When: All nursing staff to be educated on the location of confidential information being behind the clean linen closet by 5-7-18.

How: Education to be provided to the nursing staff that confidential information will be located behind the clean linen closets.

On-Going: Resident Care Director/ designee will audit to ensure that confidential information is not accessible in areas which are not locked. Executive Director will review the Audits. Results to be reviewed with Quality Assurance committee.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/25/2017		

Signature of Legal Entity Representative (Required on EVERY Page) David Pavletz

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) David Pavletz Executive Director — Date 6/1/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

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 4/6/18, there was an accumulation of lint in the lint trap of the dryer located in the 300 hall.

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.

Immediate Correction: The lint trap of the dryer on the 300 hall was removed and cleaned on 4-6-18. The nursing staff and the maintenance director will be educated on the importance of cleaning the dryer lint traps after each use.

When: Nursing staff and maintenance director will be educated and the need for the lint to be removed from the dryers after each use by 5-7-18.

How: Nursing staff and maintenance director will be educated on the need to have dryer lint traps cleaned after each use. Also, a sign will be placed on the dryer to remind all to clean the dryer lint trap after each use.

On-going: The Executive Director/Designee will audit the dryer lint traps daily to ensure that they are free of lint. The results will be reviewed with the quality assurance committee.

Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page)	David Paisley		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	David Paisley Executive Director	Date	5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.132(c) - A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

2a. DESCRIPTION OF VIOLATION

The fire drill records for the drills conducted on 8/18/17 and 9/6/17 do not include the number of residents present in the home during the 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.

Immediate Correction: Croker Fire Safety did send an updated report for 8-18-17 and 9-6-1 stating the number of residents that were present in the home during the fire drills on 8-18-17 and 9-6-17.

When: Will educate the Maintenance Director and the maintenance director will ensure that Croker Fire safety is aware that all fire drills must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating , problems encountered and whether the fire alarm or smoke detector was operative by 5-7-18.

How: Education to the maintenance director and Croker Fire Safety will be completed on the requirements of regulation 2600.132(c).

On-Going: The Executive Director/designee will audit all fire drills to ensure the they include the date, time, the amount of time it took to evacuate, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff participating, problems encountered and whether the fire alarm or smoke detector was operative. Results will be reviewed with the quality assurance committee.

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) David Pustilnik Executive Director. Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2000

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 4/4/18 at 10:55 A.M., four boxes of Resident # 2's Albuterol Sulfate was located in an unlocked cabinet of the 400 hall.

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.

Immediate Correction: On 4-4-18 resident's 2 albuterol sulfate was removed from the cabinet at the 400 hall and locked in the med cart.

When: All med techs will be educated that prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked by 5-7-18.

How: All med techs will be educated that all prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked.

On-going: The Resident Care Director/Designee will audit areas at the nursing stations weekly to ensure that they do not contain any prescription drugs, OTC medications, CAM, and syringes weekly. Results to be reviewed with the Quality assurance committee.

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) David Lovelette Executive Director — Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

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

2a. DESCRIPTION OF VIOLATION

On 4/6/18, there were three loose pills in the second drawer of the Rosewood Court Medication Cart.

On 4/6/18 there was one loose pill in the first drawer of the Arlington Court Medication Cart.

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.

Immediate Correction: On 4-6-18 the lose medications were removed from both the Rosewood and Arlington medication's carts.

When: All med techs will be educated that prescription medications, OTC medications, CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions by 5-7-18.

How: All med techs will be educated that prescription medications, OC medications, CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture, and light and in accordance with the manufacturer's instructions.

On-Going: The Resident Care Director/Designee will QA med carts weekly to ensure that the carts are free of any loose pills. Results will be reviewed with the quality assurance committee.

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 5/3/18		

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2600

2600.202 - The following procedures are prohibited:
(1) Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited.
(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited.
(5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited.
(6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

2a. DESCRIPTION OF VIOLATION

On 1/14/18 during the overnight shift, the bedroom door handle of Resident #1, a resident of the home's secure dementia care unit, was tied to an adjacent handrail on the wall in order to prohibit the door from opening and restrain the residents ability to leave the bedroom.

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.

Immediate Correction: After the facility completed its investigation in January of 2018 the staff member responsible for the act was terminated from their position. Resident #1 did not show any adverse reactions from this act of being secluded in their room.

When: Nursing staff will be educated as to the procedures that are prohibited under regulation 2600.202 by 5-7-18.

How: Nursing staff to be educated as to the procedures that are prohibited under regulation 2600.202 by the RCD.

On-going: The Resident Care Director/Designee will interview 5 staff members weekly to see if they have noted any seclusion, aversive conditioning, pressure point techniques, chemical restraint, mechanical restraint, manual restraints have been seen with any residents. Results to be reviewed with the QA committee.

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)	David Lavelle Executive Director	Date	5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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

1. REGULATION 55 Pa.Code §2800

2800.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

2a. DESCRIPTION OF VIOLATION

The pre-admission screening form for Resident # 3, admitted [redacted]18, does not include a determination that the home can meet the service needs of the resident.

The pre-admission screening form for Resident # 4, admitted [redacted]8, does not include a determination that the home can meet the service needs of the resident.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Immediate Correction: The pre-admission screening form for resident #3 and #4 were corrected to state that the home can meet the service needs of the residents.

When: The Resident Care Director, Resident Care Coordinator, Memory Care Director will be educated on the need for the preadmission screening form states that the needs of the resident can be met by the services provided by the home by 5-7-18.

How: The Resident Care Director, Resident Care Coordinator, Memory Care Director will be educated on the need for the preadmission screening form states that the needs of the resident can be met by the services provided by the home.

On-going: The Resident Care Director/ designee will audit all pre-admission screening forms to ensure that they are reflecting that we can meet the needs of the resident by the services provided by the home. Results to be reviewed with the quality assurance committee.

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) David [illegible], Executive Director | Date 5/3/18

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

The above plan of correction is approved as of 5/7/18 (Date)

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

Plan of correction implementation status as of 5/7/18 (Date)

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