pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **RAPPS SENIOR CARE LLC**
(LEGAL ENTITY)

To operate **WOODBRIDGE PLACE**
(NAME OF FACILITY OR AGENCY)

Located at **1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

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

The total number of persons which may be cared for at one time may not exceed **125** (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 21

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 **June 13, 2018** until **December 13, 2018**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 143591

Robert E. Robinson
ISSUING OFFICER

Carolyn K Ellis
DEPUTY SECRETARY

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

HS 628 – 2/18cse

pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUN 14 2018

Mr. Robert W. Chapin, Jr.
Rapps Senior Care, LLC
1000 Legion Place, Suite 1600
Orlando, FL 32801

RE: Woodbridge Place
1191 Rapps Dam Road
Phoenixville, PA 19460
License #: 143591

Dear Mr. Chapin:

As a result of the Department's Bureau of Human Services Licensing inspection on April 4, 2018 of the above facility, we have found that your facility is in substantial compliance with the regulations, set forth in 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), that can be adequately assessed at this time.

In accordance with 55 Pa.Code § 2600.11(b) (relating to procedural requirements for licensure or approval of personal care homes) a re-inspection of your newly licensed facility will be conducted within 3 months of the effective date of this license. Complete compliance with all applicable regulations is required in order to maintain your license.

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

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

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

Mr. Robert W. Chapin, Jr.

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

Sincerely,

Jacqueline L. Rowe
Director

Enclosures
License
License Inspection Summary

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

PCH Name: WOODBRIDGE PLACE	License Number: 14359
Address: 1191 RAPPS DAM ROAD, KIMBERTON, PA 19442	County: Chester
Administrator: Deb Bodnar	Region: SOUTHEAST
Legal Entity Name: Rapps Senior Care LLC	
Legal Entity Address: 1000 Legion Place, Suite 1600, Orlando, FL 32801	

Certificate(s) of Occupancy
C-2 LP
07/01/1996
PA L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 80	Waking Staff: 60
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: Parker, Shawn; Wooters, Sandra

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: 125	Number of Residents who:
Number of Residents Served: 58	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 58
Area: 1ST FLOOR	Have Mental Illness: 0
Secured Dementia Unit Capacity, If Applicable: 21	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable: 12	Have a Mobility Need: 22
Number of Current Hospice Residents: 1	Have a Physical Disability: 0
Number of Hospice Residents in past year: 4	

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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

2a. DESCRIPTION OF VIOLATION
A live feed camera, located in the hallway, is positioned able to view bedrooms 153 and 154 entrances.

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.

All live feed cameras located on the Woodbridge Place property have been disconnected by the Director of Maintenance and are no longer in use. Completed: 4-4-2018

If later the Community decides to utilize the surveillance cameras, Woodbridge Place will comply with the Audio/Visual Monitoring precepts as outlined in 42(s).

2600.42(s)

Addendum

Executive Director to contact Chester County AAA, to arrange inservicing related to Resident Rights. Emphasis will be placed on the residents right to privacy. Complete by: 6-13-2018

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/6/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.51 - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. §§ 10225.101-10225.5102) and 6 Pa.Code Chapter 15 (relating to protective services for older adults).

2a. DESCRIPTION OF VIOLATION
Staff members A, B, C and D do not have a completed Pennsylvania Criminal Background Check.

Hospice Staff member E does not have a completed Pennsylvania Criminal Background Check.

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.

Woodbridge Place will conduct criminal history checks in accordance with the Older Adult Protective Services Act (OAPSA) (35 P.S. 10225.5102) and 6 Pa Code Chapter 15 (relating to protective services for older adults). Staff members B, C, and D now have a criminal record background check on file. Staff person A is no longer employed at Woodbridge Place. Completed: 5-29-2018 The criminal record background check was obtained for hospice staff person E. Completed: 4-4-2018. (Attachment: 1)

An audit of all employee records will be completed by the Business Office Coordinator/designee. The Business Office Coordinator/designee will obtain a criminal history background check for any employee who does not have one on file. Completed by: June 13, 2018The Business Office Coordinator will obtain a criminal background check for each provisionally hired employee.

No employee will participate in the Community's orientation program unless a background check has been submitted to either e-patch or if out of state greater than 2 years, the FBI check. The Business Office Coordinator/designee will track the necessary documentation to ensure criminal record background checks are included in the employee file. No employee will be allowed to continue employment if e-patch results are not obtained within 30 days of hire or if a FBI check is not received within 90 days of hire.

Any issues identified with this procedure will be reviewed and discussed at the Quality Assurance Meeting scheduled for June 14, 2018.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/11/18 (Date)

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

2600.51

Addendum

Any outside care provider including but not limited to hospice, home health personnel or personal care aides, will have a completed PA Criminal Record Background Check or FBI (if applicable) prior to start date in the Community. The Business Office Coordinator will be responsible to ensure compliance with this procedure. (Completed: 4-4-2018). The Business Office Coordinator will inservice the Designee r/t the completion of the Background Check Audit Tool. Audit Tools will be maintained in the community in the Quality Assurance Binder. Completion by: June 13, 2018.

Deb Bodnar Sr. Executive Director

DEB Bodnar, Sr. Executive Director

6-7-18

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600

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

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

2a. DESCRIPTION OF VIOLATION

Staff person A, whose first day of work was on 03-05-18, didn't complete the following until 03-07-18:

Evacuation procedures.
Staff duties and responsibilities during fire drills, during emergency evacuation, transportation and at an emergency location, if applicable.
Designated Meeting Place.
Smoke detectors and fire alarms.

Staff Person A didn't complete the following until 03-17-18:

Location of fire extinglshers
Smoking safety procedures

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.

REFER TO NEXT PAGE

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/11/18 (Date)

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

65(a)

Prior to or on the first day of work, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers at Woodbridge Place will have a general fire safety and emergency preparedness orientation that includes: (1) Evacuation Procedures) (2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location as applicable (3) The designated meting place outside the building or within the fire safe area in the event of an actual fire (4) Smoking Safety Procedures, policy and location of smoking areas. (5) the location of fire extinguishers (6) Smoke detectors and fire alarms (7) Telephone use and notification of emergency services. Completed: 4-4-2018

An audit of all employee training has been initiated by the Business Office Coordinator/Designee. Any staff person that has not completed the General Fire Safety and Emergency Preparedness Orientation will be provided with same immediately. Completed By: June 13, 2018

A new form has been implemented which outlines the necessary components of the general fire safety and emergency preparedness orientation. This form requires the presenter to document (check-off) the completion of each component and to sign/date the General Fire Safety and Emergency Preparedness Form when the orientation is completed. (Attachment: 2) Prior to filing the Orientation Form in the Employee Record, the Business Office Coordinator/designee will review the orientation to ensure completion within the regulated timeframe. Any issues identified during this review will be corrected immediately with the staff person/presenter. Completed by: June 13, 2018

Outcomes of this review will be discussed by the Business Office Coordinator at the Quality Assurance Meeting scheduled for June 14, 2018.

Deb Bodnar
DEB BODNAR, SR. EXECUTIVE DIRECTOR
5-31-18

2600.65(a)

Addendum

The Business Office Coordinator will inservice the designee r/t the completion of the General Fire and Safety Audit Tool. Audit tools will be maintained in the community in the Quality Assurance Binder. Completion by: June 13, 2018

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.65(e) - Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

2a. DESCRIPTION OF VIOLATION
Direct care staff person F received only 10.25 hours of annual training in training year 2017.

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.

To ensure that direct care staff persons receive high quality training and to develop their knowledge of regulations and best care practices, Woodbridge Place will provide Direct Care Staff Persons at least 12 hours of annual training relating to their job duties. Completed: 4-4-2018

All Direct Care Staff Persons will have 12 hours of annual training that will relate to their job duties.

A training schedule has been implemented which outlines the required training topics. A record of training will be kept including the staff person trained, date, source, content, length of each course. (Attachment: 3) Completed: 5-1-2018. The training documents will be reviewed by the Executive Director monthly to ensure compliance. Any issues identified will be corrected immediately with the department head/staff person involved.

Outcomes of the Executive Director's review will be discussed at the Quality Assurance Meeting scheduled for June 14, 2018. and responsible for continued compliance (4)

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/14/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.65(i) - A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

2a. DESCRIPTION OF VIOLATION
The home's record of direct care staff training does not include Aging Process, ADL's, Self administration of medication, emergency medical plan, and reportable incidents.

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.

To comply with regulation 2600.65(i), Woodbridge Place will keep a record of training for each staff person trained, in addition to the date, source, content and length of course. Staff person F is no longer employed at Woodbridge Place. Completed: 4-4-2018

Training for all staff will be documented and will include the staff person trained, date, source of training content and length of course. Completed: 4-4-2018

The staff training schedule has been revised and now includes specific training topics as follows: Aging Process, ADL's Self administration of medication, emergency medical plan and reportable incidents. (Attachment: 4)

Training documents will be reviewed monthly by the Executive Director to ensure compliance. Any issues identified will be corrected immediately wit the staff person/presenter immediately.

Outcomes of the Executive Director's review will be discussed at the Quality Assurance Meeting scheduled for June 14, 2018.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

Plan of correction implementation status as of 6/6/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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

2a. DESCRIPTION OF VIOLATION
On 04-04-18 at 3:00 pm there was a strong odor of urine coming from bedroom #157.

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.

Sanitary conditions will always be maintained at Woodbridge Place. Room 157 was checked by community staff and it was determined that the source of the odor was the soiled clothing in the laundry basket. Clothing was immediately removed and laundered. No further odors noted in room 157. Completed: 4-4-2018

A walk through of the entire community was conducted. No further odor issues were identified. Completed: 4-4-2018

Staff has been informed to investigate/immediately correct/intervene or if necessary, report to housekeeping/maintenance department any conditions that are unsanitary. Any issues identified with sanitation will be corrected. Any patterns identified will be discussed and interventions/resolutions provided with the appropriate Department Head. Completed: 4-5-2018

Outcomes of issues identified will be discussed at the Quality Assurance Meeting scheduled for June 14, 2018.

2600.85(a)

Addendum

All staff will be inserviced r/t maintaining sanitary conditions in the building. Emphasis will be placed on infection control as well as follow through/intervention. The Director of Maintenance/Housekeeping will be responsible for compliance. Completion by: June 13, 2018

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/4/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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

2a. DESCRIPTION OF VIOLATION
3 small salads were leftover from lunch. They were observed in dining room not labeled, or dated.

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

Food served and returned from a resident plate may not be served again or used in preparation of other dishes. Leftover food shall be labeled and dated. The 3 small salads left over from lunch were thrown out. Completed: 4-4-2018

A review of the kitchen/dining room revealed no other items that were left unlabeled or undated. Completed: 4-4-2018

All dietary staff will be inserviced r/t labeling and dating left over food. Emphasis placed on the importance of identifying food items and the length of time the food has been in storage. Cross – contamination of food items was also reviewed. Completed by: 6-1-2018

The Dietary Manager/designee will conduct a Quality Assurance review to ensure all food items are labeled and dated. Dietary personnel will throw out any items that do not have a label or is not dated. Any issues will be corrected immediately with the dietary staff person involved. Outcomes of the dietary review will be discussed by the Dietary Manager at the Quality Assurance meeting scheduled for June 14, 2018

2600.103(e)

Addendum

Audits Forms will be maintained in the community in the Quality Assurance Binder.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/11/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.103(g) - Food shall be stored in closed or sealed containers.

2a. DESCRIPTION OF VIOLATION
The container of fish cakes in the kitchen was opened and unsealed.

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.

To ensure that foods are protected from spoilage or infestation, Woodbridge Place will store all foods in closed or sealed containers. The fish cakes observed to be in an unsealed container were thrown out. Completed: 4-4-2018

A review of the kitchen/dining room revealed no other items stored in unsealed containers. Completed: 4-4-2018

All dietary staff will be inserviced r/t the storage of foods in closed containers. Emphasis placed on contamination and spoilage of foods. Completed by: June 1, 2018 The Dietary Manager/designee will conduct a Q.A. review to ensure all food items or stored properly in sealed containers. Dietary personnel will throw out of any items that are not properly sealed. Any issues will be corrected immediately with the dietary staff person involved.

Outcomes of the dietary review will be discussed by the Dietary Manager at the Quality Assurance meeting scheduled for June 14, 2018

2600.103(g)

Addendum

Audit Forms will be maintained in the community in the Quality Assurance Binder.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/14/18 (Date)

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

Violation Report: 14369 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant, or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

2a. DESCRIPTION OF VIOLATION
Resident # 2 was admitted on 01-28-18. The medical evaluation was completed on 10-16-17.

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.

To decide if a resident's medical, social and cognitive needs can be met at Woodbridge Place, and to assist in developing accurate assessments and support plans, each resident will have a medical evaluation by a physician, PA or CRNP documented on the form specified by DHS within 60 days prior to admission or within 30 days after admission. Completed: 4-4-2018

To ensure compliance with the regulatory timeframes of each resident Medical evaluation an audit was conducted by the Director of Nursing/Designee. All Medical Evaluations were completed within the regulated timeframe. Completed: (ongoing audit) (Attachment: 5)

An audit has been developed by the Director of Nursing. The audit will record the name and date of each resident's medical evaluation and will serve as a reference for ongoing evaluations. Newly admitted residents will be added to the audit. Any issues identified because of the audit will be corrected immediately.

The outcomes of the Medical Evaluation audit will be discussed by the Director of Nursing at the Quality Assurance scheduled for June 14, 2018.

Addendum

The Director of Nursing will inservice the designee r/t the completion of the audit tool. Completion by June 13, 2018. All Audit Tool Forms will be kept in the Quality Assurance Binder.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR, SR. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/4/18 (Date)

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

Plan of correction implementation status as of 6/11/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.143(a) - The home shall have a written emergency medical plan that includes the following:
(1) The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
(2) Emergency transportation to be used.
(3) An emergency-staffing plan.

2a. DESCRIPTION OF VIOLATION
The home's emergency medical plan does not include hospital of choice for residents # 1 and # 2.

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

Woodbridge Place will have a written emergency medical plan that includes the hospital/source of health care that will be used in the event of an emergency. Residents 1 and 2 now have their hospital preferences added to the face sheet. Completed: 4-4-2018. (Attachment: 6)

An audit of the face sheets was initiated by the Wellness Department/Concierge. Any issues noted with the identification of emergency hospital preferences will be corrected and the face sheet updated with the required information. Completed by: June 13, 2014,

As of 5-29-2018, the Community Concierge will be responsible for the completion of the revised face sheet which now includes a space to identify the emergency hospital preference. The Concierge will provide the Wellness Department with a copy of the face sheet and place a copy in the evacuation binder.

Outcomes from this procedure will be reviewed by the Concierge at the Quality Assurance Meeting scheduled for June 14, 2018.

Addendum

The Director of Nursing will inservice the Concierge r/t the completion of the Face Sheet Audit Form. Completion by: June 13, 2018. All Audit forms will be maintained in the community in the Quality Assurance Binder.

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

Signature of Legal Entity Representative
(Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) DEB Bodnar Sr. EXECUTIVE DIRECTOR

Date 5-31-18

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

The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/4/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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
The medication administration records master signature sheet is not updated monthly for the MARS on the 1st, 2nd, 3rd floors and SDU. They are all dated 2018 with no indication of month.

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.

Woodbridge Place will keep a medication record for each resident for whom medications are administered. Information included as outlined in 2600.187(a). A medication master sheet was immediately obtained for the month of April 2018 and is now included in the MARS for the 1st, 2nd and 3rd floors and SDU. Completed: 4-4-2018 (Attachment: 7)

A Medication Record Master Signature Sheet will be updated monthly for the MARS for each resident for whom medications are administered. Completed: 5-2-2018 (Attachment: 8)

The Director of Nursing/designee will be responsible to ensure that for each new month a Medication Record Master Signature sheet is obtained.

Any issues with the Medication Master Signature Sheet will be discussed by the Director of Nursing at the Quality Assurance Meeting scheduled for June 14, 2018.

see next Page

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB Bodnar Sr. EXECUTIVE DIRECTOR

Date 5-31-18

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The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/11/18 (Date)

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

2600.187(a)

Addendum

The Director of Nursing will inservice the designee r/t the completion of the Medication Record Master Signature Sheet. Completion by June 13, 2018. The audit tool will be maintained in the community in the Quality Assurance Binder.

Deb Bodnar Sr. Executive Director

Deb Bodnar, Sr. Executive Director

6-7-18

Violation Report: 14369 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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

2a. DESCRIPTION OF VIOLATION
Resident # 2 participated in the development of their support plan on 02-01-18. The resident did not sign the support plan.
Resident # 3 participated in the development of their support plan on 11-02-17. The resident did not sign the support plan.

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.

Woodbridge Place will insure that any Individuals who participate in the development of the support plan will sign and date the support plan. Residents 2 and 3 signed their support plan. Completed: 4-4-2018. (Attachment: 10)

An audit was conducted by the Director of Nursing/Designee to insure signatures participants were included on the Support Plan. Any issues identified were corrected. Completed: 4-5-2018

Prior to filing the Support Plan in the Support Plan file, the DON/Designee will insure that participants (including residents, staff and family members) are documented on the signature page of the support plan. Any issues identified will be corrected immediately and signatures obtained by the DON/designee.

Any issues identified with the review process will be discussed at the Quality Assurance Meeting scheduled for June 14, 2018.

Addendum

The Director of Nursing will inservice the designee r/t to support plan signatures and follow through with corrective action. Completion by June 13, 2018.

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

Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB BODNAR SR. EXECUTIVE DIRECTOR

Date 5-31-18

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The above plan of correction is approved as of 6/1/18 (Date)

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

Plan of correction implementation status as of 6/4/18 (Date)

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

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

1. REGULATION 55 Pa.Code §2600
2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
Resident # 4 was admitted to the SDCU on [redacted]18. The medical evaluation did not document the resident's need for SDCU care.

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.

For each resident, Woodbridge Place will obtain a medical evaluation for each resident from a physician, physician assistant or CRNP documented on a form provided by DHS within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's Disease or other Dementia and the need for the resident to be served in a secured dementia unit. The medical evaluation for resident 4 was amended to include the need to be served in a secured dementia unit. Completed: 4-4-2018. (Attachment: 10)

An audit was completed by the DON/designee. Results of this audit revealed that all medical evaluations for the residents currently residing in the secured dementia unit have documentation of the resident's need for SDCU care. This audit will be ongoing.

Before filing the medical evaluation in each resident's clinical record, the DON/designee will review each evaluation to ensure that all necessary documentation is recorded on the form. Any issues identified following this review will be corrected immediately.

Issues identified with the medical evaluation form will be reviewed and discussed by the Director of Nursing at the Quality Assurance Meeting scheduled for June 14, 2018.

See next page

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Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEB Bodnar Sr Executive Director — Date 5-31-18

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The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 6/1/18 (Date)

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

2600.231(b)

Addendum

The Director of Nursing will inservice the designee r/t the completion of the Medical Evaluation Form Audit. Completion by June 13, 2018. The audit tool will be maintained in the community In the Quality Assurance Binder.

Deb Bodnar Sr. Executive Director
DCB Bodnar, Sr. Executive Director
6-7-18

Violation Report: 14359 - 04/04/2018 - Parker, Shawn
PCH Name: WOODBRIDGE PLACE

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 directions for operating the home's locking mechanism are not conspicuously posted near the door to the SDCU courtyard egress.

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.

Woodbridge Place will post directions for the operation of any locking devices that are used to lock and unlock exits to prevent immediate egress. Operation directions are now posted near the door to the SDCU courtyard egress. Completed: 4-4-2018

On 4-4-2018, an audit of all locking devices was conducted by the Community Director of Maintenance. Results of this audit revealed that each locking device in the Community has operational directions posted conspicuously near the device. Completed: 4-4-2018

If at any time a code is updated for a locking device, the Director of Maintenance/designee will post new operational directions conspicuously near the device.

Any issues identified with this procedure will be reviewed/discussed at the Quality Assurance Meeting scheduled for June 14, 2018.

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

Signature of Legal Entity Representative
(Required on EVERY Page) Deb Bodnar

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Deb Bodnar Sr Executive Director

Date 5-31-18

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- ☐ Not Implemented

Violation Report: 14359 - 04/04/2018 - Parker, Shavn
PCH Name: WOODBRIDGE PLACE

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

2a. DESCRIPTION OF VIOLATION
Resident # 4 was admitted to the SDCU on [redacted]18. The residents initial support plan was developed [redacted]18.

Resident # 5 was admitted to the SDCU on [redacted]18. The residents initial support plan has not been completed as of [redacted]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.

Woodbridge Place will within 72 hours of an admission or within 72 hours prior to the resident's admission to the secured dementia unit, will develop a support plan, implement and file the support plan in the resident's record. The support plan for resident 4, who was admitted to the secured dementia care unit on [redacted]2018 had a support plan developed that was not within the regulatory timeframe. The support plan for resident 5 was completed, implemented and filed as of 3-29-18. (Attachment 11)

The Director of Nursing audited the support plans for all residents currently residing in the secured dementia care unit. The results of this audit revealed that all residents had a support plan developed, implemented and filed within the regulatory time frames. Audits maintained for Department Review (w)

An audit form has been developed by the Director of Nursing to insure compliance with regulatory times frames for the development, implementation and filing of the Resident Support Plan. Names of newly admitted residents to the Secured Dementia Care Unit will be added upon admission. Any issues that are identified because of this ongoing audit will be addressed by the Director of Nursing for immediate correction.

Issues that have been identified because of this audit will be reviewed and discussed by the Director of Nursing at the Quality Assurance Meeting scheduled for June 14, 2018.

See Next Page

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Signature of Legal Entity Representative (Required on EVERY Page) Deb Bodnar

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Date 5-31-18

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

2600.234(a)

Addendum

A copy of the Support Plan audit tool will be maintained in the community in the Quality Assurance Binder .

Deb Bodrom Sr. Executive Director

Deb Bodrom Sr. Executive Director

6-7-18