



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

OCT 30 2018

Mr. Matthew Coleman  
Authorized Signatory  
North Wales 1089 MC BG OPCO, LLC  
330 North Wabash Avenue, Suite 3700  
Chicago, Illinois 60611

RE: Park Creek Place – Memory Care  
1089 Horsham Road  
North Wales, Pennsylvania 19454  
License #: 142560

Dear Mr. Coleman:

As a result of the Department's Bureau of Human Services Licensing annual inspection on August 13, 2018 and August 14, 2018 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

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

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

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

Sincerely,

Jacqueline L. Rowe  
Director

Enclosure  
License Inspection Summary



Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

**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, who is an agency employee, first day of work was 8/3/2018. They did not receive orientation in 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

**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.*

Staff A is no longer working at the community.  
 New employees, including agency staff, will receive the required orientation prior to being placed on the schedule.  
 The Business Office Manager (BOM) and/or designee will audit new employee files within 3 days of hire, and prior to being placed on the schedule, to ensure required orientation is complete, x 3 months.  
 Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
 The Administrator is responsible for sustained compliance. Monitoring will be ongoing.


Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Christine L. Kline Date 10/1/2018

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

The above plan of correction is approved as of 16/19/18  
 (Date)

The above plan of correction was approved by   
 (Initials)

Plan of correction implementation status as of 10/19/18  
 (Date)

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

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

**1. REGULATION 55 Pa.Code §2600**

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

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

**2a. DESCRIPTION OF VIOLATION**

The annual training provided to direct care staff person B in training year 2017 did not include training in infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

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

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

Direct Care Staff person B completed the required training in infection control and general principles of cleanliness and hygiene, and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration on October 3 or October 4th at the Mandatory Staff meeting. New Direct Care staff will receive the required orientation prior to being placed on the schedule. The Business Office Manager (BOM) and/or designee will audit new employee files within 3 days of hire, and prior to being placed on the schedule, to ensure required training is complete, x 3 months. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The Administrator is responsible for sustained compliance. Monitoring will be ongoing.

Repeat Violation: No

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*Christine L. Kline*

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Christine L. Kline

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
- (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
- (3) Resident rights.
- (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
- (5) Falls and accident prevention.
- (6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION

Direct care person B did not receive training in The Older Adults Protective Services Act and falls and accident prevention during 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.*

Direct Care Staff person B will complete the required training in The Older Adults Protective Services Act, and falls and accident prevention on October 3, 2018 or October 4, 2018 at the mandatory staff meeting. New Direct Care staff will receive the required orientation prior to being placed on the schedule. The Business Office Manager (BOM) and/or designee will audit new employee files within 3 days of hire, and prior to being placed on the schedule, to ensure required training is complete, x 3 months. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The Administrator is responsible for sustained compliance. Monitoring will be ongoing.

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Printed Name and Title of Legal Entity Representative  
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Violation Report: 14266 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600  
 2600.101(j)(2) - Each resident shall have the following in the bedroom: A chair for each resident that meets the resident's needs.

2a. DESCRIPTION OF VIOLATION  
 Bedroom C1 has 2 residents. There are no chairs present in room.

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


The chairs for Bedroom C1 were placed on the day of inspection.  
 The Maintenance Technician (MT) and/or designee will audit 5 resident rooms/week x 4 weeks, then 3 resident rooms/week x 4 weeks, then 1 resident room weekly x 4 weeks, to ensure chairs are present for each resident. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <small>Christine L. Kline</small>	Date <small>10/12/2018</small>
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Violation Report: 14255 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600  
 2600.101(j)(7) - Each resident shall have the following in the bedroom: An operable lamp or other source of lighting that can be turned on at bedside.

2a. DESCRIPTION OF VIOLATION  
 Bedroom A3 does not have a source of light that can be turned on/off from bedside.

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.

Upon further investigation, it was discovered that the resident in Bedroom A3 had moved the lamp. The lamp was returned to the nightstand on day of inspection. The Maintenance Technician (MT) and/or designee will audit 5 resident rooms/week x 4 weeks, then 3 resident rooms/week x 4 weeks, then 1 resident room weekly x 4 weeks, to ensure lamps are present at the bedside for each resident. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The Administrator is responsible for sustained compliance. Monitoring will be ongoing.

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denisa  
 PCH Name: PARK CREEK PLACE MEMORY CARE

**1. REGULATION 55 Pa.Code §2600**

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

**2a. DESCRIPTION OF VIOLATION**

On 8/14/18 there were 3 pitchers containing what appeared to be cranberry juice and 2 pictures containing what appeared to be orange juice present in refrigerator #1. There were no labels or open dates present on the pitchers.

On 8/14/18 there was a plastic container with a lid containing what appeared to be fruit cocktail present in refrigerator #3 in the kitchen. There was no label or open date on container.

On 8/14/18 a metal bowl covered in plastic wrap containing what appeared to be vanilla pudding present in refrigerator #3 in the kitchen. There was no label or open date on the bowl or plastic wrap.

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

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

The juice, fruit cocktail and vanilla pudding were discarded immediately.  
 The Chef was re-trained on procedure to label and date food on August 23, 2018 by the Dining Services Manager.  
 The Kitchen staff were re-trained on procedure to label and date food on August 23, 2018 by the Dining Services Manager.  
 The ED and/or designee will check refrigerated food 5x/week x 4 weeks, then 3x/week x 4 weeks, then weekly x 4 weeks, to ensure items are labeled and dated. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
 The Chef is responsible for sustained compliance. Monitoring will be ongoing.

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600

2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION

There are four emergency exit doors in the hallways of the home that are labeled as an exit. The doors are alarmed with a red alarm box in the shape of a stop sign and labeled "STOP alarm will sound". This can cause a resident to hesitate or deter them from using the exit in an emergency.

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

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

The word STOP was removed from the signs on the exit doors on August 23, 2018.

The Maintenance Technician was trained on the requirement on August 23, 2018 by the Administrator and the Regional Director of Operations. Picture attached.

The ED and/or designee will check exit doors during routine rounds weekly x 3 months to ensure there are no STOP signs present on exit doors. Audits will be discussed in monthly QI meetings.

The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The Maintenance Technician is responsible for sustained compliance. Monitoring will be ongoing.

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Violation Report: 14255 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

**1. REGULATION 55 Pa.Code §2600**

2600.123(c) - For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

**2a. DESCRIPTION OF VIOLATION**

The home does not have emergency evacuation diagrams posted in the home. There is one evacuation diagram hung under a shelf and is partially hidden behind a telephone on the receptionist's desk. This is not posted in a conspicuous and public place and not visible or accessible to residents or visitors in the event of an emergency.

**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.*

Emergency evacuation diagrams were posted by the Regional Director of Operations on August 23, 2018. The MT was re-educated regarding the requirement for posting emergency evacuation diagrams on August 23, 2018 by the Regional Director of Operations. Picture attached. The ED and/or designee will check emergency evacuation diagrams during routine rounds weekly x 3 months to ensure they remain in place. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The MT is responsible for sustained compliance. Monitoring will be ongoing.

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Date 10/12/2018

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600

2600.141(a) ( ) 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

The medical evaluation for resident Resident #1, dated 6/26/18, does not include medication regimen. Also section 7 on page 2 of the document of medical evaluation is blank..

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.*

Resident #1's medical evaluation was completed on June 26, 2018, including the medication regimen and section 7.

The Care Services Manager (CSM) was re-trained on the requirement to include the medication regimen with the medical evaluation and completion of section 7.

The ED and/or designee will audit 5 resident records/week x 4 weeks, then 3 resident records/week x 4 weeks, then 1 resident record weekly x 4 weeks, to ensure medical evaluations include the medication regimen and completion of section 7. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.

The CSM is responsible for sustained compliance. Monitoring will be ongoing

*The CSM will review all Resident DME's when the prescriber HAS completed the evaluation to ensure all required elements of the DME have been completed, starting immediately.*

*SD 10/19/18*

Repeat Violation: No

Date(s) of Previous Violation(s):

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600  
 2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION

Resident #2 has a medical evaluation completed on 9/15/15 and 12/11/17 documented in residents record. There is no documented annual medical evaluation for 2016.

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

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

Resident #2's 2016 medical evaluation cannot be corrected. Current annual medical evaluation will be completed prior to 12/10/18.

The CSM was re-trained on the requirement for annual evaluations on (DATE) by (WHOM).

The ED and/or designee will audit 5 resident records/week x 4 weeks, then 3 resident records/week x 4 weeks, then 1 resident record weekly x 4 weeks, to ensure annual evaluations are completed.

Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.

The CSM is responsible for sustained compliance. Monitoring will be ongoing

Repeat Violation: No

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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

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 8/14/18, one white oval pill and one white capsule were found loose in the the second drawer of the South 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.

The loose pills were discarded on the date of inspection.  
 The Med Techs will be re-trained on organization and proper conditions of sanitation by Care Services Manager on October 3, 2018 or October 4, 2018 at the mandatory staff meeting.  
 The CSM and/or designee will audit the med carts weekly x 3 months to ensure it remains organized and in proper condition of sanitation. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

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

Resident #1 is prescribed Hydrocortisone Cream 2.5% Ointment Apply to bilateral lower extremity twice daily as needed for itching and Acetaminophen 325mg tablets Take two tablets by mouth every 6 hours as needed for pain/fever. Medications are not present in medication cart or home for residents use.

Resident #3 glucometer readings are not recorded on the MAR. Resident has a physicians order to inject 30 units of Levemir 100/unit /ml when blood sugar reading is equal to or greater than 130. There are readings in residents glucometer but there are no recorded blood glucose levels in Resident #3's record except for 8/4/18.

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.*

Resident #1's hydrocortisone cream and acetaminophen were re-ordered on August 23, 2018.  
 Current Glucometer results for resident #3 are recorded on the MAR.  
 The Med techs were re-trained on re-ordering medications timely and recording glucometer results on August 23, 2018 but Care Services Manager.  
 The CSM and/or designee will audit current as needed orders to as needed medication availability for 5 residents/week x 4 week, then 3 residents/week x 4 weeks, then 1 resident/ week x 4 weeks, to ensure current as needed medications are available as ordered. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
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Violation Report: 14258 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

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

2a. DESCRIPTION OF VIOLATION


Staff member C signed off on resident #1's medication administration record that Latanoprost 0.005% Drops (Instill 1 drop each eye at bedtime for glaucoma) was given on 7/1/18 through 7/17/18 at 8pm. Through staff interviews it was determined that this medication was not given to resident.

Resident #3's Glucometer has no blood glucose readings on dates 8/6/18, 8/8/18, 8/9/18 and 8/12/18. Residents order for Levemir 100unit/ml is to inject 30 units when blood sugar reading is equal to or greater than 130. The residents medication administration record is signed off that 30 units of Levemir 100u/ml were given on dates 8/1/18 through 8/13/18 indicating that the home gave the medication without checking the residents blood sugar level.

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.*

Staff member C is no longer employed at the community.  
 Med techs were re-trained on following the directions of the prescriber by Care Services Manager on August 23, 2018.  
 The CSM and/or designee will observe and audit medication administration, including glucometer checks and documentation, for 5 residents/week x 4 week, then 3 residents/week x 4 weeks, then 1 resident/ week x 4 weeks, to ensure directions of the prescriber are followed. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The CSM is responsible for sustained compliance. Monitoring will be ongoing


*Resident #3 Glucometer results are now recorded on the MAR. The CSM will compare the Residents Glucometer readings with the recorded results on the MAR to ensure the information is correct, starting immediately.*  
 10/19/18

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Christine L. Kline Date 10/1/2018

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The above plan of correction is approved as of <u>10/19/18</u> (Date)	Plan of correction implementation status as of <u>10/19/18</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600

2600.224(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

There is no preadmission screening form for resident #4, admitted 6/1/18.

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.

Resident #4's pre-admission screening cannot be corrected as resident moved in on 6/1/18.  
 The CSM was trained on the pre-admission screening requirement on August 23, 2018 by the Administrator  
 The ED and/or designee will audit resident records prior to move-in x 3 months to ensure the pre-admission screening form is completed. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance  
 The CSM is responsible for sustained compliance. Monitoring will be ongoing

The administrator will review the needs of Resident #4 to determine if the home can meet the needs of the Resident by the services provided by the home, within the next 10 days of receipt of this plan of correction.

② 10/19/18

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Christine L. Kline	Date 10/1/2018
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The above plan of correction is approved as of <u>10/19/18</u> (Date)	Plan of correction implementation status as of <u>10/19/18</u> (Date)
The above plan of correction was approved by <u>SK</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

**1. REGULATION 55 Pa.Code §2600**

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

**2a. DESCRIPTION OF VIOLATION**

Resident #4's initial assessment plan dated 5/30/18 does not properly evaluate or identify hearing, vision, dental, or incontinence needs.

**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.*

Resident #4's initial assessment cannot be corrected as it was dated 5/30/18. The current Assessment and support plan, completed on September 20, 2018 by Care Services Manager, includes the proper evaluation for hearing, vision, dental and incontinence needs.  
 The CSM was trained on this requirement on August 23, 2018 by the Administrator.  
 The ED and/or designee will audit initial assessments for new admissions within 15 days of admission x 3 months. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
 The CSM is responsible for sustained compliance. Monitoring will be ongoing

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page)

*Christine L. Kline*

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


Christine L. Kline

Date 10/1/2018

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The above plan of correction is approved as of 10/19/18  
 (Date)

Plan of correction implementation status as of 10/19/18  
 (Date)

The above plan of correction was approved by   
 (Initials)

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

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

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

The assessment for resident #5, dated 6/27/18, has a need identified that resident wanders into other residents bedrooms. The resident's support plan does not document how this need will be met.

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.

Resident #5's current support plan was updated on September 20, 2018 by Care Services Manager to identify the need that resident wanders into other residents bedrooms.  
 The CSM was trained on this requirement on August 23, 2018 by the Administrator.  
 The ED and/or designee will audit 5 resident records for wandering residents/week x 4 weeks, then 3 resident records/week x 4 weeks, then 1 resident record weekly x 4 weeks, to ensure the support plan includes how the resident's need will be met. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
 The CSM is responsible for sustained compliance. Monitoring will be ongoing

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page)

*Christine L. Kline*

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

Christine L. Kline

Date 10/1/2018

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The above plan of correction is approved as of

10/19/18  
 (Date)

Plan of correction implementation status as of

10/19/18  
 (Date)

The above plan of correction was approved by

  
 (Initials)

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

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 65 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 #1's support plan dated 8/7/18 does not contain a signature or mark indicating that resident is unable/refused to sign or participate.  
 Resident #4's support plan dated 5/30/18 does not contain a signature or mark indicating that resident is unable/refused to sign or participate.  
 Resident #4's support plan dated 5/30/18 is not signed by anyone who participated in the development of 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.

Resident #1's support plan was reviewed with the Resident's responsible party on 9/20/2018.  
 Resident #4's support plan was updated on 9/20/2018, is signed by anyone who participated in the development of the support plan, and is signed by Care Services Manager  
 The CSM was trained on this requirement on 8/23/2018 by the Administrator .  
 The Administrator and/or designee will audit 5 resident records /week x 4 weeks, then 3 resident records/week x 4 weeks, then 1 resident record weekly x 4 weeks, to ensure the support plan includes a signature or mark indicating that resident is unable/refused to sign or participate, and is signed by anyone who participated in the development of the support plan. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance

The CSM is responsible for sustained compliance. Monitoring will be ongoing

All Resident Support Plans will indicate if the Resident participated in the development of the support plan. If the Resident participated the CSM will attempt to obtain a Resident signature and the attempts made to obtain a signature or mark will be documented on the Support Plan, starting immediately (C) 10/19/18

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

Signature of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*      Date *10/17/2018*

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

The above plan of correction is approved as of 10/19/18 (Date)

Plan of correction implementation status as of 10/19/18 (Date)

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

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

Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600  
 2600.227(h) - If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

2a. DESCRIPTION OF VIOLATION  
 Resident #1's support plan dated 8/7/18 does not contain a signature or mark indicating that resident is unable/refused to sign or participate.  
 Resident #4's support plan date 5/30/18 does not contain a signature or mark indicating that resident is unable/refused to sign or participate.

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.

Resident #1's support plan was reviewed with the Resident's responsible party on (DATE).  
 Resident #4's support plan was updated on (DATE), is signed by anyone who participated in the development of the support plan, and is signed by (WHOM)  
 The CSM was trained on this requirement on (DATE) by (WHOM).  
 The Administrator and/or designee will audit 5 resident records /week x 4 weeks, then 3 resident records/week x 4 weeks, then 1 resident record weekly x 4 weeks, to ensure the support plan includes a signature or mark indicating that resident is unable/refused to sign or participate, and is signed by anyone who participated in the development of the support plan. Audits will be discussed in monthly QI meetings.  
 The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance.  
 The CSM is responsible for sustained compliance. Monitoring will be ongoing

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Christine L. Kline	Date 10/1/2018
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The above plan of correction is approved as of <u>10/19/18</u> (Date)  The above plan of correction was approved by <u>(SK)</u> (Initials)	Plan of correction implementation status as of <u>10/19/18</u> (Date)  <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
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Violation Report: 14256 - 08/13/2018 - Gillespie, Denise  
 PCH Name: PARK CREEK PLACE MEMORY CARE

1. REGULATION 55 Pa.Code §2600  
 2600.236 - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

2a. DESCRIPTION OF VIOLATION  
 Direct care staff person B had only 1 hour of training in dementia care during 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.

Direct Care staff person B completed 6 hours of annual training related to dementia care and services on (DATE). (note: if not done, by what date will it be completed on?)  
 Direct Care staff will receive the required annual training related to dementia care and services per calendar year. The Business Office Manager (BOM) and/or designee will audit current employee files monthly x 3 months, to ensure required training is complete. Audits will be discussed in monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on 3 consecutive months of compliance. The Administrator is responsible for sustained compliance. Monitoring will be ongoing.

STAFF B will receive 11 hours of Dementia related training and documentation will be maintained. In addition to the required 12 hours of Annual DC Staff training, prior to 12/31/18.  
 (S) 10/19/18

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) *Christine L. Kline*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Christine L. Kline	Date 10/1/2018
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The above plan of correction is approved as of 10/18/18  
 (Date)

Plan of correction Implementation status as of 10/19/18  
 (Date)

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

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