pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: December 27, 2018

Ms. Winnona Kissinger,
Executive Director
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 #: 332101

Dear Ms. Kissinger:

As a result of the Department's Bureau of Human Services Licensing inspection on October 24, 2018, October 25, 2018, December 11, 2018, December 12, 2018 and December 13, 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.

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

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: Winona Kissinger	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
Labor & Industry

Staffing Hours
Resident Support: 0 Total Daily Staff: 117 Waking Staff: 88

Type of Inspection: Partial BHA Docket Number: 034-18-0005 Notice: Unannounced

Reason(s) for Inspection(s)
Complaint, Settlement

On-Site Inspections Dates and Department Representatives On-Site
10/24/2018: McCloskey, Jason; Hoover, Douglas
10/25/2018: McCloskey, Jason; Hoover, Douglas

Off-Site Inspection Dates and Inspectors, if Applicable
11/29/2018: McCloskey, Jason

Other Details
Partial or Full Triggers: Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 166

Number of Residents Served: 94

Secured Dementia Care Unit in Home: Yes

Area: Arlington & Rosewood neighborhoods

Secured Dementia Unit Capacity, if Applicable: 28

Number of Residents Served in Secured Dementia Care Unit, if applicable: 22

Number of Current Hospice Residents: 5

Number of Hospice Residents in past year: 33

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 94

Have Mental Illness: 6

Have an Intellectual Disability: 1

Have a Mobility Need: 23

Have a Physical Disability: 1

Violation Report: 33210 - 10/24/2018 - McCloskey, Jason
PCH Name: SENIOR COMMONS AT POWDER MILL

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

2a. DESCRIPTION OF VIOLATION
On 10/24/18 at approximately 4pm, Staff Person A administered medications to Residents 3 and 4. The staff person popped medications from the blister cards into his/her ungloved hand prior to placing the tablets into a plastic cup for administration.

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

On 10/24/18 The med tech was immediately re-educated and counseled on correct medication administration activities which includes the following activities:

1. identify the correct resident
2. If indicated by the prescribers orders measure vital signs and administer medications accordingly
3. remove the medication from the original container. 4 Crush or split the medication as ordered by the prescriber
5. Place the medication in the medication cup or appropriate container or the resident's hand
6. Place the medication in the resident's hand, mouth, or other route as ordered by the prescriber, in accordance with the limitations specified in 2600.182b (4). 7. Complete documentation in accordance with 2600.187 (relating to medical records).

The Administrator, Certified Medication Administration Trainer or designee shall observe a med pass weekly for each staff responsible for medication administration for a period of four weeks. After which each Med Tech will be observed once per month for a period of three months. Documentation of the observations shall be maintained by the home for Department Review. All med techs who offer medication assistance or medication administration will be re-educated on sanitary conditions as outlined in Plan of Correction (Attachment A) by Dec 21, 2018. Documentation of retraining will be maintained for department review. The RN or designee will monitor for compliance. Executive Director will complete random audits to assure compliance.

Q.A. audit findings will be reported at the Q.A. meetings.

(Continued on Page 2A)

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

Signature of Legal Entity Representative Required on EVERY Page) Winona Kissinger, Executive Director

Printed Name and Title of Legal Entity Representative Required on EVERY Page):
Winona Kissinger, Executive Director

Date 11/21/2018

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

The above plan of correction is approved as of 12/10/18 (Date)

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

Plan of correction implementation status as of 12/13/18 (Date)

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

Plan of Correction (Attachment A)

Regulation 2600.85 (a)- Sanitary conditions shall be maintained.

Discussion: "Sanitary conditions" can include many different situations in a personal care home. While unsanitary conditions will often be determined on a case-by-case basis, they generally include the following: • Feces, human or animal • Urine, human or animal • Bodily fluids, such as blood, mucus, vomit, or semen • Rotten or spoiled foods • The presence of mold or mildew • Pungent odors • Extremely unclean surfaces

According to the Centers for Disease Control (CDC), insulin vials and penlet devices should not be used for more than one resident. These precautions help to prevent the transmission of the Hepatitis B virus, Hepatitis C virus, and HIV. Each resident who is prescribed insulin must have his/her own insulin vial, syringe, lancets, testing strips, and glucometer. It is recommended that these items be labeled with the resident's name or stored in a container that is labeled with the resident's name.

Primary Benefits: Greatly minimizes the risk of resident illness, rodent and insect infestation, and provides dignified living conditions for residents.

Action Plan: On 10/24/18 a Med Tech popped medications from the blister cards into his/her ungloved hand prior to placing the tablets into a plastic cup for administration. All med tech will be trained to follow the appropriate medication administration (see Attachment B). See Page 3B

Winona Kissinger, Executive Director 11/21/2018

Violation Report: 33210 - 10/24/2018 - McCloskey, Jason
PCH Name: SENIOR COMMONS AT POWDER MILL

1. REGULATION 55 Pa.Code §2600

2600.182(c) - Medication administration includes the following activities, based on the needs of the resident:

(1) Identify the correct resident.
(2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
(3) Remove the medication from the original container.
(4) Crush or split the medication as ordered by the prescriber.
(5) Place the medication in a medication cup or other appropriate container, or in the resident's hand.
(6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in § 2600.182(b)(4).
(7) Complete documentation in accordance with § 2600.187 (relating to medication records).

2a. DESCRIPTION OF VIOLATION

On 10/24/18 at approximately 10am, inspectors observed Resident 5 kneeling at the foot of his/her bed and placing medications which were sitting on the bed into his/her mouth. This resident lives in the Arlington secure dementia care unit. Staff failed to observe the resident ingest the medication.

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

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

On 10/24/18 the Med Tech was immediately re-educated and counseled on the 5 rights of medication administration and Regulation 2600.182(c). Medication administration which includes the following activities based on the needs of the resident.

When administering medications, staff may: • Remove all of the medications prescribed for administration to one resident from their containers, place all of the medications in a cup, hand the cup to the resident, observe the resident ingest the medications, and then document administration of the medication. • Remove medications from their containers 2 hours before the scheduled administration time, place the medications in a cup labeled with the resident's name, and lock the cup in a secure place prior to administration.

Staff may not: • Remove the medications from their containers, put all of the medications into a cup, and carry the cup to a resident who is not present in the medication administration area or near the medication cart. • Document the administration of a medication prior to giving the medication to a resident . • Neglect to observe a resident ingest his medications. • Fill multiple cups with multiple residents' medications, place the cups on a tray, leave the medication area, disburse the medications, and then return to the medication area to log the medications as administered. • Remove medications from their containers more than 2 hours before the scheduled administration time. • Remove medications from an original container and place them into another container for purposes of a day activity or a vacation (based on the needs of the resident, options to consider for vacations or time away from the home include using individually-labeled unit dose packs with complete pharmacy labels on each dose), asking the pharmacist to prepare a properly-labeled container for the time away from the home, or releasing the entire prescription container to the resident or his designated person.

All Med Techs will be re-educated on proper medication administration procedures as outlined in the Plan of Correction (Attachment B) by Dec. 21, 2018. Documentation of retraining will be maintained for department review. The RN or designee will be responsible to monitor to assure compliance. Executive Director will complete random audits to assure compliance.

(Continued on Pages 3A, 3B and 3C)

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

Signature of Legal Entity Representative (Required on EVERY Page) Winona Kissinger, Executive Director

Printed Name and Title of Legal Entity Representative (Required on EVERY PAGE): Winona Kissinger Executive Director — Date 11/21/18

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

The above plan of correction is approved as of 12/10/18 (Date)

The above plan of correction was approved by BAS

Plan of correction implementation status as of 12/13/18 (Date)

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

2600.182(c) Continued

The Administrator, Certified Medication Administration Trainer or designee shall observe a med pass weekly for each staff responsible for medication administration for a period of four weeks. After which each Med Tech will be observed once per month for a period of three months. Documentation of the observations shall be maintained by the home for Department Review.

Q.A. audit findings will be reported at the Q.A. meetings.

Norma Kissinger
Executive Director 12/14/18

Plan of Correction (Attachment B)

Regulation 2600.182 (c)- Medication administration includes the following activities, based on the needs of the resident: (1) Identify the correct resident. (2) If indicated by the prescriber's orders, measure vital signs and administer medications accordingly. (3) Remove the medication from the original container. (4) Crush or split the medication as ordered by the prescriber. (5) Place the medication in a medication cup or other appropriate container, or in the resident's hand. (6) Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in § 2600.182(b)(4). (7) Complete documentation in accordance with § 2600.187 (relating to medication records).

Discussion:

Medication administration activities in a personal care home generally fall into three categories: 1. Medications that are self-administered by a resident with no assistance from staff 2. Medications that are self-administered by a resident with some assistance from staff 3. Medications that are administered by staff to residents

Self-Administration - A resident who desires to self-administer medications must be permitted to do so if (s)he is capable of self-administering medications. The ability to self-administer is determined through the preadmission screening, medical evaluation, and assessment-support plan processes.

In order to be considered capable of self-administering medications a resident must: • Be assessed by a physician, physician's assistant or certified registered nurse practitioner as being capable of self-administering medications and his/her need for medication reminders. • Be able to recognize and distinguish his/her medications • Know how much medication is to be taken • Know when medication is to be taken, either at a specific time or based on daily activities (such as "after lunch" or "at bedtime") • Be able to remove the medication from the container • Take or apply the medication

Staff persons may perform the following tasks for a resident who meets the above criteria: • Storage of the medication • Reminding the resident to take his or her medication at prescribed times • Bringing the medication to the resident • Opening the medication container

Even if staff persons perform these tasks, the resident is still "self-administering" the medication.

A resident who does not need any assistance with self-administering medications may store the medications in his/her room. In accordance with § 2600, the medications must be kept locked to protect against contamination, spillage, misuse by other residents, and theft. If a resident has a private room, or if a resident shares a room with another resident who self-administers medication, locking the door when the room is empty is sufficient to meet the locking requirement. In all other cases, a locking drawer or lock-box is required.

A resident may be able to self-administer some medications but not others; this will be specified on the Documentation of Medical Evaluation form and the Resident Assessment-Support Plan.

Winnie Kissinger
Winnie Kissinger, Executive Director

11/21/2018

Residents who self-administer medications must be assessed annually or after a significant change in status to ensure that they are able to continue self-administering medications.

Administration by the Home - Medications may only be administered to residents by a: • Physician • Licensed dentist • Licensed physician's assistant • Registered nurse • Certified registered nurse practitioner • Licensed practical nurse • Licensed paramedic • Graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home. • 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 • Staff person who has completed the Department's medication training course (may not administer IVs or injections other than insulin and epinephrine)

Medication administration is performed in the following order: 1. The staff person identifies that (s)he is about to administer medication to the correct resident. 2. The staff person measures the resident's vital signs, if ordered to do so by the prescriber. 3. The staff person removes the medication from its original container . 4. The staff person crushes, splits, or otherwise prepares the medication as ordered by the prescriber . 5. The staff person places the medication in a cup, container, or into the resident's hand or other route, as indicated by the prescriber . 6. The staff person documents that the medication has been administered.

When administering medications, staff may: • Remove all of the medications prescribed for administration to one resident from their containers, place all of the medications in a cup, hand the cup to the resident, observe the resident ingest the medications, and then document administration of the medication. • Remove medications from their containers 2 hours before the scheduled administration time, place the medications in a cup labeled with the resident's name, and lock the cup in a secure place prior to administration.

Staff may not: • Remove the medications from their containers, put all of the medications into a cup, and carry the cup to a resident who is not present in the medication administration area or near the medication cart. • Document the administration of a medication prior to giving the medication to a resident . • Neglect to observe a resident ingest his medications. • Fill multiple cups with multiple residents' medications, place the cups on a tray, leave the medication area, disburse the medications, and then return to the medication area to log the medications as administered. • Remove medications from their containers more than 2 hours before the scheduled administration time. • Remove medications from an original container and place them into another container for purposes of a day activity or a vacation (based on the needs of the resident, options to consider for vacations or time away from the home include using individually-labeled unit dose packs with complete pharmacy labels on each dose), asking the pharmacist to prepare a properly-labeled container for the time away from the home, or releasing the entire prescription container to the resident or his designated person

Primary Benefits: Ensures that medication is administered correctly and safely.

Action Plan: On 10/24/18 a resident was observed kneeling at the foot of his/her bed and placing medications which were sitting on the bed into his/her mouth. The Med Tech failed to observe the resident ingest the medication.

Winnie Kissinger
Winnie Kissinger, Executive Director 11/21/2018

Violation Report: 33210 - 10/24/2018 - McCloskey, Jason
PCH Name: SENIOR COMMONS AT POWDER MILL

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 record (MAR) for Resident 1 does not include the diagnosis or purpose for the following medications:
-Ketoraolac Sol 0.5%
-Ocusoft Lid Pad Scrub
-Prednisolone Acet 1% susp

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

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

On 10/24/18 the MAR for resident 1 was corrected to include the diagnosis for the Ketoraolac Sol 0.5%, Ocusoft Lid Pad Scrub, and Prednisolone Acet 1% susp.
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.
A daily report will be run from the eMAR on each shift to identify any missing diagnosis. All Med Techs will be re-educated on proper medication administration procedures as outlined in the Plan of Correction (Pages 4A and 4B) by Dec. 21, 2018. Documentation of training will be maintained for department review. A The RN or designee will be responsible to monitor to assure compliance. Executive Director will complete random audits.

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

Signature of Legal Entity Representative (Required on EVERY Page) Winona Kissinger Executive Director

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Winona Kissinger Executive Director | Date 11/21/18

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

The above plan of correction is approved as of 12/10/18 (Date)

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

Plan of correction implementation status as of (Date) 12/13/18

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

Plan of Correction (Attachment C)

Regulation 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.

Discussion: The medication administration record is commonly referred to as the MAR. Proper MAR use is critical, as it: • Creates a record of proper medication administration • Allows physicians and emergency personnel to know when a medication was last administered • Creates a system to account for medications, especially controlled substances.

What medications must be recorded on the MAR? • Prescription medications • OTC medications • Vitamins • CAM

What medications are not required to be recorded on the MAR? • Nutritional supplements • Special diets

Nutritional supplements and special diets do not need to be recorded on the MAR, but the home must be aware of and provide nutritional supplements and special diets if ordered by a physician.

Remember, homes are responsible for ensuring that residents may take OTC medications without causing allergic reactions or impacting prescription medications prescribed to the resident.

What administration information must be recorded on the MAR? If several pills are packaged together in one blister pack and administered together at the same time, information for each pill in the blister must be listed individually on the MAR; the reason for this relates to residents' right to refuse medications. If a person refuses to take a pill or if one or more of the pills in the blister is not administered, the home must have a means of documenting the refusal.

The administration of a medication by a source outside of the home (such as a monthly scheduled injection in a physician's office or medication administered while visiting family) should not be documented on the MAR for the home. Only medication given by staff members of the home are to be documented on the MAR. However, any documentation given to the resident as a result of receiving administration of a medication by a source outside of the home (such as invoices, doctor's notes; etc) should be kept in the resident's record for reference purposes.

Diagnosis must be included because the same medications may be used to treat different conditions.

If there is a specific time of administration listed on the medications record, such as 8:00 AM and 8:00 PM, the actual clock time of each administration is not required to be recorded. The record can simply include staff initials. This means the medication was given within 60 minutes plus or minus the specified time. If the medication record does not list a clock time (such as am, pm, at breakfast, after lunch) the exact time of administration must be recorded. Other information - Pro re nata (PRN) means on an "as needed" basis.

Wimma Kissinger
Wimma Kissinger, Executive Director 1/21/2018

"Special precautions" include any specific administration instructions such as: causes drowsiness, take with food, do not take with certain types of other drugs, and so on.

The medication record may include the staff person's initials (in lieu of the staff person's full name) if there is a master key showing each staff person's initials, his or her full printed name, and his or her signature/signature stamp, so the individual staff person can be linked to the specific MAR entry.

Electronic Signatures - An electronic signature is permissible, as long as the computer system allows only the appropriate person to sign that a medication was administered to a resident.

Primary Benefits: The home's staff persons will be able to track all medications a resident receives and to ensure all medications are administered as prescribed.

Action Plan: On 10/24/18 the medication administration record (MAR) for a resident didn't include the diagnosis or purpose for the following medications: Ketoraolac Sol .5%, Ocusoft Lid Pad Scrub, Prednisolone Acet 1% susp. All prescribed medications must include the diagnosis. At the change of shift, the Med Tech leaving their shift will run the report for missing diagnosis (see Attachment F)

Winnd Kissinger
Winnd Kissinger, Executive Director 11/21/2018

Violation Report: 33210 - 10/24/2018 - McCloskey, Jason
PCH Name: SENIOR COMMONS AT POWDER MILL

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

2a. DESCRIPTION OF VIOLATION
Resident 6 had orders beginning 7/11/18 and ending 8/9/18 for Warfarin Tab 2.5mg, take 1 and 1/2 tablets by mouth daily every 3rd day of a 3 day cycle. The resident did not receive this medication from 7/31/18 through 8/8/18.

Resident 6 had orders beginning 7/11/18 and ending 8/9/18 for Warfarin Tab 2.5mg, take 1 tablet 1st and 2nd day of a 3 day cycle. The resident did not receive this medication from 7/30/18 through 8/8/18.

Resident 7 did not receive Prochlorper Tab 10mg from 9/14 through 9/25/18.

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.

A reportable incident had been completed on 8/9/18. The original order was entered in our QuickMar eMAR system on July 11, 2018, noting the days of the month for the rest of July. The first eight days of August were missed due to the previous month starting on the 11th. The pharmacy entered the order incorrectly into QuickMAR so the medication was not showing in our administration times for those days. The PCP was called and told us to resume the current order. Blood work is ordered in one week. The family was notified.
All med techs will be re-educated by Dec 21, 2018 on how to approve orders in QuickMAR by watching the QuickMAR Supervisor training videos on how to approve orders and the procedures outlined in the Plan of Correction (Attachment D). Documentation of retraining will be maintained for department review.
When the Med Tech approves orders from the Pharmacy; compare label with prescription to assure the 5 rights are correct, the label must be then be compared to the MAR to assure the ordered was entered correctly in QuickMAR by the pharmacy. When administering each medication, the med tech must compare the pharmacy label with the MAR matching the 5 rights. Med Techs are responsible to assure all resident medications are on hand and available by completing medication cart audits twice weekly on Mondays and Thursdays.

The RN will complete an initial audit that reconciles the current orders with the MAR. The LPN or designee will review orders daily for any changes. Monthly thereafter the RN or designee will reconcile orders with the MAR

The RN or designee will be responsible to maintain compliance. Executive Director will complete random audits to assure compliance.

(Continued on Page 5A)

Repeat Violation: Yes	Date(s) of Previous Violation(s):	01/31/2018		

Signature of Legal Entity Representative (Required on EVERY Page) Kimm Kissinger, Executive Director

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

Date 12/21/18

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

The above plan of correction is approved as of 12/10/18 (Date)

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

Plan of correction implementation status as of 12/13/18 (Date)

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

Plan of Correction (Attachment D)

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

Discussion: This includes the direction of a prescribed treatment, such as the use of medical equipment or therapy.

Primary Benefits: Ensures that residents receive medications and treatments as ordered by a physician.

Action Plan: On 10/24/18 a resident had orders beginning 7/11/18 and ending 8/9/18 for Warfarin Tab 2.5 mg, take 1 and ½ tablets by mouth daily every 3rd day of a 3 day cycle. The resident did not receive this medication from 7/31/18 through 8/8/18. Also that same resident had orders beginning 7/11/18 and ending 8/9/18 for Warfarin Tab 2.5 mg, take 1 tablet on the 1st and 2nd days of a 3 day cycle. The resident did not receive this medication from 7/31/18 through 8/8/18. A different resident did not receive Prochlorper Tab 10 mg from 9/14 through 9/25/18. When the Med Tech approves orders from the Pharmacy; compare label with prescription to assure the 5 rights are correct, the label must be then be compared to the MAR to assure the ordered was entered correctly in QuickMAR by the pharmacy. When administering each medication, the med tech must compare the pharmacy label with the MAR matching the 5 rights. Med Techs are responsible to assure all resident medications are on hand and available by completing medication cart audits twice weekly on Mondays and Thursdays.

Winnie Kissinger Winnie Kissinger Executive Director 11/21/2018

Violation Report: 33210 - 10/24/2018 - McCloskey, Jason
PCH Name: SENIOR COMMONS AT POWDER MILL

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
The initial assessment for Resident 2 was completed on 11/17/17, more than 15 days from the resident's date of admission.

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

On 10/24/18 an initial assessment for a resident was completed 11/17/17. This was completed more than 15 days from the resident's admission date.

All admissions from 9/1/18 to 11/29/18 (15 Residents) will be audited to assure the assessment and support plan were completed timely. Going forward the Executive Director or designee will review RASP on day 14 to assure timeliness of completion.

Executive Director will re-educate all designated staff who complete initial assessments of the 15 day requirement of regulation 2600.225(a) by Dec 21, 2018. Documentation of training will be maintained for the Department's review. Executive Director will run a monthly report in Tabula Pro to assure all RASP dates are in compliance.

Contiuned on Page 6A

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

Signature of Legal Entity Representative (Required on EVERY Page) Winona Kissinger Executive Director

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

Date 11/21/18

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

Plan of correction implementation status as of 12/13/18 (Date)

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

Plan of Correction (Attachment E)

Regulation 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.

Discussion: The Department uses a single document to both assess a resident's needs and develop a plan to meet those needs. This form is known as the Resident Assessment-Support Plan, or RASP. A copy of the RASP is available on the Department's website or by contacting the Operator Support Hotline.

Primary Benefits: Allows homes to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.

Action Plan: Noted on 10/24/18 an initial assessment for a resident was completed 11/17/17. This was completed more than 15 days from the resident's admission date.

Will re-educate all designated staff who complete initial assessments of the 15 day requirement of regulation 2600.225(a). Executive Director will run a monthly report in Tabula Pro to assure all RASP dates are in compliance.

Winona Kissinger
Winona Kissinger, Executive Director 11/21/2018