



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFICATE OF COMPLIANCE**

This certificate is hereby granted to CLARKS SUMMIT AID II OPCO LLC  
LEGAL ENTITY

To operate WILLOWBROOK PLACE  
NAME OF FACILITY OR AGENCY

Located at 150 EDELLA ROAD, CLARKS SUMMIT, PA 18411  
(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 80  
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller  
(MAXIMUM CAPACITY)

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 July 12, 2019 until January 12, 2020,  
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **226591**

Robert E. Robinson  
ISSUING OFFICER

Carolyn K. Ellison  
DEPUTY SECRETARY

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



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: July 12, 2019**

Tri M. Tran  
Vice President, Treasurer and Secretary  
Clarks Summit AID II OPCO LLC  
330 North Wabash Avenue, Suite 3700  
Chicago, Illinois 60611

RE: Willowbrook Place  
150 Edella Road  
Clarks Summit, Pennsylvania 18411  
Certificate #: 226591

Dear Provider:

As a result of the Department's Bureau of Human Services Licensing annual inspection on January 25, 2019, March 26, 2019 and May 31, 2019 of the above facility, the citations specified on the enclosed violation report were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), your current license # 226590 dated May 3, 2019 to May 3, 2020 is **REVOKED**. A **FIRST PROVISIONAL** license is being issued. This **FIRST PROVISIONAL** license replaces all previously issued licenses and is effective for six months from the date of issuance. The license dated May 3, 2019 to May 3, 2020 is **NOT** reinstated upon expiration of this **FIRST PROVISIONAL** license. This decision is made pursuant to 62 P.S. 1026(b)(1) and 55 Pa.Code § 20.71(a)(2) (relating to conditions for denial, nonrenewal or revocation.) Your **FIRST PROVISIONAL** license is enclosed.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

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


Tri M. Tran

2

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

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

Sincerely,



Jacqueline L. Rowe  
Director

Enclosures  
License  
Violation Report



Violation Report: 22659 - 01/25/2019 - Valence, Duane  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**

2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

**2a. DESCRIPTION OF VIOLATION**

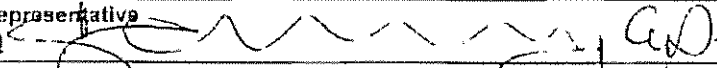
The home failed to submit an incident report to the Department's Northeastern Regional Licensing Office based on a Report of Need for Protective Services on Resident # 1 and an investigation of suspected abuse conducted by the Lackawanna County Area Agency on Aging on 1/14/2019. The home failed to submit a written incident report within 24 hours as required by this regulation.

**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.*

(See Attached)

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) CHRIS MURRAY CEO Date 5/8/19

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

The above plan of correction is approved as of 5-13-19  
 (Date)

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

Plan of correction implementation status as of 6-17-19  
 (Date)

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

2600.16(c)

- Resident #1 no longer resides at the community as of January 10, 2019.
- The Executive Director was re-trained on the requirement on April 29, 2019 by Anne Graziano, DHS, through phone call and email, dated April 29, 2019; that if a protective service investigator identifies themselves to staff in the building, the assumption must be made (correct or not) that there has been an allegation of a need for protective services (abuse, abandonment, neglect or exploitation).
- Current staff was educated on May 2, 2019 regarding immediately reporting suspected abuse in accordance with the older adult protective act.
- The Executive Director is responsible for sustained compliance.
- The ED, and/or the Designee, will review reports of alleged abuse to ensure the home has reported immediately in accordance with the older adult's protective act every three months, monitoring will be ongoing.
- Submitting an incident report to the Department's North East Regional Office to be included with this POC.

The Administrator will also provide a training to all staff on the other 18 events that are reportable and ensure that there is a process to submit Incident Reports to the Regional Office within the 24 hour timeframe as required. The training should take place within 15 days of the receipt of this Approved Plan of Correction. The Administrator will provide a copy of the training material and a copy of the Employee Sign in sheet following this training. 6-17-19

ag

 CHAS MURRAY  
ED, 5/8/19

Violation Report: 22659 - 01/25/2019 - Valence, Duane  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**

2600.23(a) - A home shall provide each resident with assistance with activities of daily living as indicated in the resident's assessment and support plan.

**2a. DESCRIPTION OF VIOLATION**

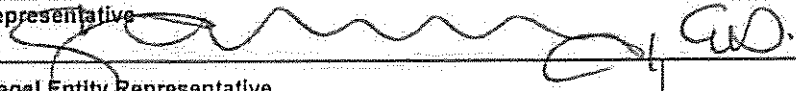
The Description of Services Need in Resident # 1's Assessment and Support Plans dated 1/1/18 and 12/19/18 indicates that showers are provided 2 x weekly by Direct Care Staff. The home failed to provide this identified service even though Resident #1 refused showers. The home offered no additional assistance or services following these refusals.

**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.*

(See ATTACHED)

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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Charles Murray, CEO Date 5/8/19

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The above plan of correction was approved by <u>AG</u> (Initials)	<input type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input checked="" type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

4A

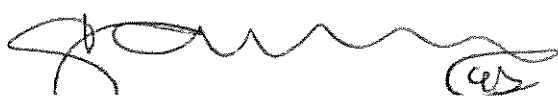
2600.23(a)

- Resident #1 no longer resides at the community.
- Current staff will be trained on offering additional assistance when a resident consistently refuses services and notifying the resident's responsible party with consistent refusals for services by April 19, 2019 by the Lead LPN and Executive Director (ED); and on the four elements of Elder Abuse (Abuse, Abandonment, Neglect, and Exploitation) by May 2, 2019 by Executive Director.
- The Care Services Manager is responsible for sustained compliance. The Executive Director and/or designee will audit the RASP and documentation for residents refusing services x three months to ensure compliance. Monitoring will be ongoing.

see 15:

The Administrator will ensure that the Wellness Team understands how information is to be gathered and subsequent care is provided based on Resident's Resident Assessment and Support Plan (RASP). The Administrator will oversee the organization and flow of information regarding resident care needs from the direct care staff up to supervisors and management. The Administrator will also over see information moving from Management and the Supervisors to the Direct Care Staff. The administrator will ensure that the process put into place ensures that each resident will have their needs met and how to meet them, along with a communication system to relay problems or concerns with care. 6-17-19

AG

 Chris Murray  
 5/8/19

Violation Report: 22659 - 01/25/2019 - Valence, Duane

PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**

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

**2a. DESCRIPTION OF VIOLATION**

Upon Resident # 1's admission to Geisinger CMC on 1/10/2019, they presented with Stage 2 decubiti on the sacral area. From 12/13/18, when Resident #1's PCP identified a decline, until the resident's admission to the hospital on 1/10/19, the home neglected to render necessary care due to an absence of assistance with showers or observation to ensure the resident's skin integrity. Resident #1 was diagnosed with stage 2 decubiti on the sacral area upon admission to the hospital on 1/10/19.

**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.*

(See Attached)

Repeat Violation: No

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(Required on EVERY Page)

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

Date

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(Date)

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(Initials)

Plan of correction implementation status as of 6-17-19  
(Date)

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

5A

2600.42(b)

- Resident #1 no longer resides in our community.
- The Willowbrook Place has a zero tolerance for any act or failure to act that causes harm to a resident.
- The home will train staff to identify methods to avoid neglect related to acts by staff or agents of the home, or harm resulting from failure to act by the home or agents of the home by initiating the use of skin care audit forms weekly on shower days for all current residents and also notifying the Doctor and the family when a resident refuses a shower more than two times per week.
- Current staff will be educated regarding the use of these forms and checking skin integrity while providing care needs by May 2, 2019 by Lead LPN and ED and on the four elements of Elder Abuse (Abuse, Abandonment, Neglect, and Exploitation) by the Executive Director.
- Current licensed staff will also be educated regarding documenting skin integrity prior to leaving our community by May 2, 2019 by Lead LPN and ED.
- The home will ensure strict communication between staff and the home and the LPN's, CSM and ED in meeting the needs of the residents.
- The Care Service Manager is responsible for sustained compliance. The ED and/or designee will review resident records for residents who leave the community to ensure compliance for three months. Monitoring will be ongoing.

The Administrator will ensure that the aspects of abuse, abandonment, neglect or exploitation are broad based and cover all elements of care, not just skin integrity, showers or refusals of service(s). The information provided by the Lackawanna County Area Agency on Aging will be applied to all of the services the home provides. Questions or concerns should be addressed to the local aging office or the Regional Office.  
6-17-19

ag



Chris Murzik  
CW

Rev. 5/17/19 CAM  
5/8/19

Violation Report: 22659 - 01/25/2019 - Valence, Duane  
 PCH Name: WILLOWBROOK PLACE

**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 home's RASP completed on 12-18-18 failed to reflect the PCP's assessment in the resident record on 12-13-18 in the following areas:


- Transferring in/out of bed/chair
- Ambulating
- Degree of Supervision
- Mobility Status
- Behavioral/Cognitive Care Needs
- Summary and Determination

**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.*

(See Attached)

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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Chris Murray, Esq.	Date 5/8/19
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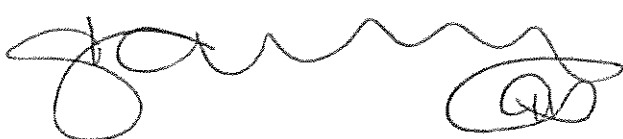
6A

2600.227(d)

- The home's RASP completed on 12-18-18 cannot be corrected as the resident no longer resides at the community.
- The Executive Director and the Care Services Manager will be re-trained regarding the requirement for documenting in the resident's support plan 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 by April 19, 2019 by The Regional Director of Care Services. In addition, current staff will be in serviced on appropriate lines of communication directing staff who and how to report changes or concerns in a resident's condition, and on reviewing updated RASP's to ensure resident care needs are met.
- The Care Services Manager is responsible for sustained compliance.
- The Executive Director and/or designee will audit physician orders and/or documentation to identify any referrals for current residents, and updates to the RASP are completed, to ensure compliance x 3 months. Monitoring will be ongoing.

The home will put into place a comprehensive communication system to share information from direct care staff to management and back in the other direction when reporting problems, providing skills or approaches in providing care to residents, and properly being able to recognize and react to a change or decline in the resident's condition and how the home will respond. These efforts will be documented on the RASP Addendums. 6-17-19

AG



Chris MURRAY  
aw.

5/8/19



Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

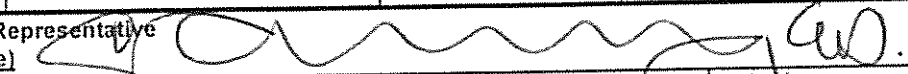
1. REGULATION 55 Pa.Code §2600  
 2600.88(a) - Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION  
 The nose of each step located in the "B" side of the building stairwell leading from the second to the first floor were covered with yellow tape that was loose or torn on each step leading from the second to the first-floor exit. The loose yellow tape could cause a slipping or tripping hazard for residents using the stairs in this area of the home.

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

(see attached)

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

Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Chris Murphy, Executive Director      Date 6/13/19

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2A

**Willowbrook Place – Plan of Correction for Annual.**

*Submission of this response and plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response of plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*

2600.88(a)

- This was immediately fixed at the time of inspection. The yellow tape that was loose on the B side stairwell steps leading from the second to first floor was removed as to not cause a slipping or tripping hazard for residents using the stairs in this area of the home.
- Yellow tape was also removed from all side stairwells at this time to avoid a tripping hazard.
- Maintenance Manager is responsible for sustained compliance.
- ED/Designee with monitor for compliance.

6-14-19

MM

Chris Murray  
Executive Director



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**

2600.91 - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**2a. DESCRIPTION OF VIOLATION**

There were no emergency telephone numbers required by this regulation posted on or near the landline telephone located in Resident #1's bedroom 126. There were no emergency telephone numbers posted on or near Resident #2's living room landline phone in bedroom 203.

**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.*

(See attached)

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
 (Required on EVERY Page)

*[Handwritten Signature]* E.D.

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

*James Murray, Executive Director*

Date

*6/13/19*

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

The above plan of correction is approved as of 6-14-19  
 (Date)

Plan of correction implementation status as of 6-14-19  
 (Date)

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

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

3A

2600.91

- This was fixed at time of inspection.
- Emergency telephone numbers were immediately replaced for the bedroom phone of room 126 and the living room phone of 203 as required by this regulation.
- All current resident phones were re-checked for these numbers as well.
- Housekeepers and RCP's were re-trained at our staff meeting on 5/30/2019 to watch for these emergency phone number tags, that they are not removed by the residents. (See Attachment #1)
- Housekeepers and RCP's will ensure sustained compliance as they enter the current resident's rooms.
- Housekeeping Manager and LPNs and/or designee will monitor for this compliance ongoing.

6-14-19

MM

CHRIS MURRAY  
Executive  
Director



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

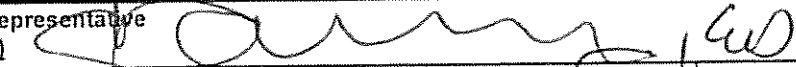
1. REGULATION 55 Pa.Code §2600  
 2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION  
 The single lever sink faucet located in the bathroom of resident room 212 needs repair or replacement. The faucet lever in the hot position allowed very little hot water to flow from the faucet. The Maintenance Director who was present at the time indicated the faucet may need a new mixing cartridge or the faucet needs to be replaced.

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.

(See attached)

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

Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Chris Murray, Executive Director      Date 6/13/19

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4A

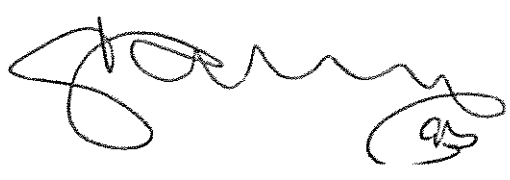
2600.95

- Maintenance Manager, Rob Naro checked the single sink faucet located in the bathroom of resident room 212 on the day after the inspection. He indicated that it did need a new mixing cartridge. He replaced the mixing cartridge at this time.
- Maintenance Assistant and Maintenance Manager then tested the flow and temperature from the faucet to ensure compliance.
- Maintenance Manager will continue to ensure sustained compliance going forward.
- ED and/or Designee will monitor as well.

6-14-19

MM

Chris Murray  
ED



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**  
 2600.100(a) - The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

**2a. DESCRIPTION OF VIOLATION**  
 The cinder block stairs located outside of the back gate from the rear patio and designated smoking area exits to grade. There is one cinder block paver cracked on a step and a second cinder block paver which is loose and flipped when stepped on. These damaged cinder block pavers create a hazardous situation for residents or staff who may use the cinder block stairs to exit the building.

**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.

(See attached)

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Chris Murray, Executive Director Date 6/13/19

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5A

2600.100(a)

- Our Maintenance Assistant and Maintenance Director, Rob Naro, evaluated the cinder block stairs outside the back gate from the rear patio for safety on March 28, 2019, two days after inspection. They indicated that two steps did need replacing to ensure safety for the residents or staff who may use those stairs.
- They replaced the two steps on March 29, 2019 to avoid any further hazardous situations with the paver steps.
- Maintenance Manager is responsible to ensure ongoing compliance.
- ED and/or designee will monitor as well.

6-14-19

MM

Chris Murray  
ED



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

**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**  
 Two wicker chairs were observed off to the side of the front entrance of the home. These two chairs were positioned in front of a stairway leading from a basement emergency exit. These chairs were obstructing an egress from the building.

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

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Christina Murray Executive Director* Date *6/13/19*

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GA

2600.121(a)

- This violation was immediately fixed at the time of inspection. The two wicker chairs that sit on our front porch were moved away from the basement stair gate and put back with their set on the side of the porch.
- The residents and staff were reminded that if a resident moves one of the wicker chairs for their liking, that they must be put back to their original spots to avoid obstructing a possible egress from the building.
- All staff is responsible for sustained compliance as they enter and exit the building.
- Ed and/or designee will monitor as well.

6-14-19

MM

Chris Murray  
ED.



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**

2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

**2a. DESCRIPTION OF VIOLATION**

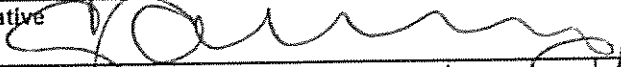
The letter from the fire safety expert dated 9-6-2018 does not indicate where residents are to evacuate to in the granted time of 10 minutes, either to the outside of the building or to the home's fire safe areas.

**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.*

(See attached)

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Chris Murray, Executive Director Date 6/13/19

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

The above plan of correction is approved as of <u>6-14-19</u> (Date)  The above plan of correction was approved by <u>MM</u> (Initials)	Plan of correction implementation status as of <u>6-14-19</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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7A

2600.132(d)

- Our fire safety expert, Chief Connolly, was attempted to be reached at the time of inspection about his incompleteness of the fire letter. He was unable to be reached.
- On 3/27/2019, Chief Connolly stopped by to accurately complete the missing item on his current letter dated 9/6/2018. He admitted to failing to circle "fire safe areas".
- The letter was correct as of 3/27/2019 and re-entered into our Survey Ready Binder. (See Attachment #2)
- Maintenance Director, Rob Naro, who contacts the chief on an annual basis will be responsible for ongoing sustained compliance.
- Ed and/or Designee will monitor as well.

6-14-19

MM

Chris MURPHY  
AD



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

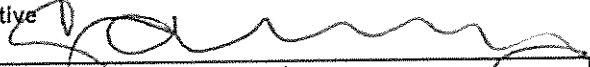
1. REGULATION 55 Pa.Code §2600  
 2600.141(a)(2) - The medical evaluation must include the following: (1) through (10)

2a. DESCRIPTION OF VIOLATION  
 The Documented Medical Evaluation for Resident #3 dated 10/17/2018 was incomplete. Resident # 3's temperature reading under section (1) General Physical Examination was blank,  
 The Documented Medical Evaluation for resident #4 dated 3/7/2019 was incomplete. The Height listed for Resident #4 under section (1) General Physical Examination was not completed.

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.

(See attached)

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Chris Mureny, Executive Director Date 6/13/19

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The above plan of correction was approved by <u>MM</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

2A

2600.141(a)(2)

- The Documented Medical Evaluation for Resident #3 dated 10/17/2018 was missing her temperature reading under section 1 when it was returned from the PCP. Lead LPN, Wendy Sebolka, filled this in on 3/27/2019 after calling the PCP for accurate documented information. Also, The Documented Medical Evaluation for resident #4 dated 3/7/2019 was missing her height under section 1 when it returned from the PCP. Lead LPN, Wendy Sebolka, also filled this in on 3/27/2019 after doing the same.
- Lead LPN notified both PCP's independently reminding them that all items on the DME must be filled out prior to them returning to the facility in order to be in state compliance.
- Lean LPN and or CRM and or Designee will ensure proper ongoing compliance by double checking each DME that is returned from a doctor's office before filing into the resident's chart.
- CSM/ED and or designee with monitor for continued compliance.

6-14-19

MM

Chris Murray  
ED



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK PLACE

**1. REGULATION 55 Pa.Code §2600**  
 2600.144(c)(1) - Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

**2a. DESCRIPTION OF VIOLATION**  
 The home has an outside smoking area located to the back of the facility adjacent to the back outside patio. Several cigarette butts were observed on the ground of the smoking area and were not disposed of in the two smoke towers available in the smoking area for disposing of cigarettes. Cigarette butts were also observed in mulch outside of the exit gate from the smoking areas.

**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.

(See attached)

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

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) Chris Murray, Executive Director Date 6/13/19

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9A

2600.144(c)(1)

- This violation was immediately fixed and the time of inspection when all cigarette butts were picked up and disposed of properly. Two proper cigarette disposal towers are present at each end of our smoking area, however these butts were still found on the grounds.
- Our two resident smokers that use that area were reminded that their cigarette butts must be disposed of in the proper towers and re-shown where they are located.
- Maintenance Assistant and Maintenance Director will be responsible for continued sustained inspections of this area for compliance going forward.
- Any new resident that smokes will also be taught of this disposal procedure.
- Ed and or designee will monitor as well for compliance.

6-14-19

MM

Chris Murray  
ED.



6/13/19

Violation Report: 22659 - 03/26/2019 - DeVries, Kristin  
 PCH Name: WILLOWBROOK 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**

Resident #4 has a 20mg Furosemide prescription; the directions on the medication record (MAR) state "Take 1 40mg tab by mouth every day." These directions are incorrect, as the resident must take 2 20mg tablets, to equal a 40mg dose.

Resident #4 has a PRN order for Tramadol. The home's narcotic count sheet indicates that this medication was administered to the resident on 3-4-19 at 8:00pm. The resident's MAR was not completed to indicate this medication was administered and who administered it.

**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.*

*(See attached)*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative *[Signature]* **AWD.**  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative *Executive Director* Date **6/13/19**  
 (Required on EVERY Page) **Chris Murray**

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

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The above plan of correction was approved by <u>MM</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

10A

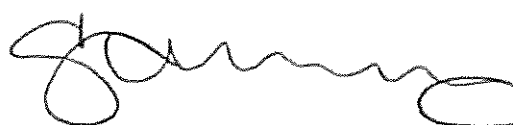
2600.187(a)

- Resident #4 directions on the MAR for the Furosemide match the doctor's order for such. The 20mg tablet bubble packs were sent back to the pharmacy to obtain the correct mg tablets to match the doctor's order and the MAR.
- Lead Med Tech and or LPN will monitor this going forward for sustained compliance that the milligrams sent from the pharmacy exactly match the MAR and MD order.
- CSM and or LPN will also monitor for compliance.
- Resident #4 PRN for Tramadol was administered to the resident on 3/4/19 at 8:00pm. The Med Tech failed to fill out the MAR appropriately, however did document it on the narcotic log sheet correctly.
- Med Tech was re-trained on the proper procedure to document on the front and back of the MAR and on the Narcotic Sheet Log as well, each time a narcotic is given.
- Lead Med Tech and or LPN will ensure continued sustained compliance for the narcotic procedure.
- CSM and or designee will also monitor for ongoing compliance.

6-14-19

MM

Chris Murrell  
CSM



6/13/19

# Violation Report

## Facility Information

Name: WILLOWBROOK PLACE  
Address: 150 EDELLA ROAD, CLARKS SUMMIT, PA 18411  
County: LACKAWANNA Region: NORTHEAST

License Number: 226590

## Administrator

Name: Christopher Murray Phone: 5705866028 Email: ~~ALCLICENSE@ENLIVANT.COM~~ CMURRAY@ENLIVANT.COM

## Legal Entity

Name: CLARKS SUMMIT AID II OPCO LLC  
Address: 330 N WABASH AVENUE SUITE 3700, IL, 60611

## Certificate(s) of Occupancy

Type: C-2 LP Date: Issued By:

## Staffing Hours

Resident Support Staff: 0 Total Daily Staff: ~~50~~ 49 Waking Staff: ~~45~~ 48

## Inspection

Type: Partial BHA Docket #: Notice: Unannounced  
Reason: Interim Plan of Correction Verification

## Inspection Dates and Department Representative

05/31/2019 - On-Site: Jason Harvey, Duane Valance

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: 80 Residents Served: ~~50~~ 49

### Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

### Hospice

Current Residents: 8

### Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 50  
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
Have Mobility Need: 10 Have Physical Disability: 7

05/31/2019  
Chris Murray  
Executive Director

6/14/19

60a - Staff/Support Plan

Regulations

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's letter from Fire Marshal Neal dated 9/6/18 determines that residents should be evacuated from the home within 10 minutes. The home has 3 fire safe area's but two of the fire safe area cannot accommodate all the wheel chairs in the home. The home has a total of 50 resident's in house.

Of the residents that reside in the personal care home, there are the following:

- 5 residents that require 2:1 physical assistance to transfer from their beds or chairs in order to evacuate in an emergency.
- 5 residents that require 1:1 physical assistance from staff to evacuate the home in an emergency.
- 3 resident that requires continuous verbal cueing from staff to evacuate from the home in an emergency.

On 5/28/19 from 11:00pm-7:00am, there were 3 staff persons working in the home. three staff persons cannot evacuate all residents safely based on the resident's mobility needs.

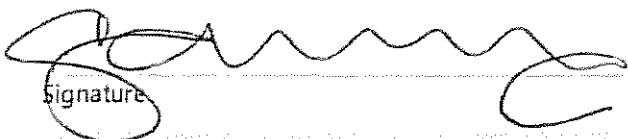
On 5/29/19 from 11:00pm-7:00am, there were 3 staff persons working in the home. Three staff persons cannot evacuate all residents safely based on the resident's mobility needs.

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.)

(See Attached)

Legal Entity Representative

  
Signature

Chris Murray, ED.  
Printed Name and Title

6/14/19  
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

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

Plan of correction implementation status as of 6-18-19 (Date)

The above plan of correction was approved by

AG  
(Initials)

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

**Willowbrook Place – Plan of Correction for June 12, 2019 Violation Report**

*Submission of this response and plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response of plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*

## 2600.60 (a)

- Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.
- Current residents were re-evaluated by LPN, Wendy Sebolka, with assistance from our Enlivant Regional Nurse, Angel Lyles, to re-evaluate and update our immobile residents properly. (See Attachment #1)
- The results which were fewer in number than Wendy had originally understood to explain properly to the inspectors in Chris's absence, were immediately updated on the resident's RASP and DME to reflect the correct changes.
- Based on 9 immobile residents, our state required hours would be 58/day with a current total of 49 residents. We are currently running an average of 115/hrs. per day in the facility. This is well covering our state requirement. (See Attachment #2)
- Given the findings on the day of this investigation, we will now staff an equivalent of four full time staff members on our overnight shifts (11-7), seven days a week. This is starting immediately. This at times may include fully trained housekeeping and dietary staff if needed.
- In addition, Willowbrook Place has a Fire Safety training program in place with Genesis Rehab, located in our facility to do quarterly Fire Safety Evaluations of all current residents to express change in needs to our CSM, LPN or designee. This not only aides in confirming mobility, but also in possible new therapy candidates at that time. This will ensure compliance going forward as well.
- CSM, LPN, and or Designee will also be responsible for sustained updates and compliance.
- ED/Designee will monitor for compliance as well.

6-18-19



132a - Monthly Fire Drill

Regulations

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

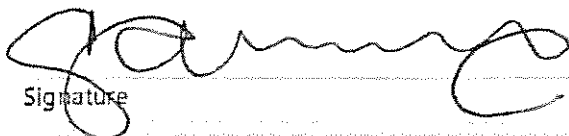
Based on residents interviews a staff person announced a fire drill to the residents before the alarms sounded during the fire drill held on 5/28/19.

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.)

(See attached)

Legal Entity Representative

  
Signature

Chris Murray, EO  
Printed Name and Title

6/14/19  
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 6-17-19  
(Date)

Plan of correction implementation status as of 6-17-19  
(Date)

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

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

2600.132. (a)

- An unannounced fire drill is held at least once a month in our facility.
- Unfortunately there was no fire drill in our facility on 5/28/19 as noted on the report. It was held on 5/29/19 by our Fire Safety Expert, Rob Naro. (See Attachments #3 & #4)
- In addition, reporter mentioned, (resident #4) has only been a resident since 5/28/2019 and has a diagnosis of Dementia as well as many others to be considered in taking her report as valid. I am including her DME to confirm. (See Attachments #5, 4 pages)
- The other reporter mentioned was her husband, who is a resident of the nearby Skilled Nursing Center, who also could not report accurately on our procedures.
- Also, as mentioned by the inspectors of a tall blonde announcing this drill on the incorrect day; there was no tall blonde working on 5/29/19. We do however have a tall blonde demented resident that resides on the second floor where the report was taken, that does confuse herself as a staff member and may have been mistaken as an employee making these announcements, but she would never have any idea when a drill would be done.
- Our Fire Safe expert and Maintenance Director, Rob Naro, will ensure sustained compliance of not announcing any fire drill to the staff or residents as he runs these drills monthly.
- ED and or designee will ensure continued compliance as well.

6-17-19

Chris Murray  
ED



6/14/19

132h - Designated Meeting Place

Regulations

2600.

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

Description of Violation

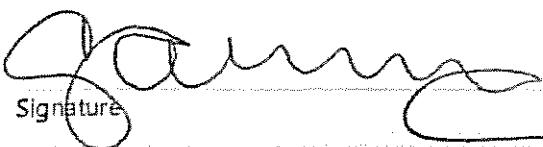
Based on resident's interviews and admission from the home's administrator the residents are not evacuating to fire safe area or outside the building during fire drills when the weather is cold outside, residents meet in the lobby of the building for fire drills. Based on the home's fire safety letter dated 9-8-18, the lobby has not been identified as a fire safe area.

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.)

(See attached)

Legal Entity Representative

  
Signature

Christ Murray, ED.  
Printed Name and Title

6/14/19  
Date

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The above plan of correction is approved as of

6-17-19  
(Date)

Plan of correction implementation status as of

6-17-19  
(Date)

The above plan of correction was approved by

AG  
(Initials)

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

2600.132 (h)

- Residents shall evacuate to our designated meeting place away from the building or within the fire safe areas during each fire drill.
- As previously discussed in our Annual Renewal POC, our chief never circled where we should be evacuating to on each monthly fire drill. He since corrected that letter and circled "fire safe areas". (See Attachment #6)
- What the reporter probably was referring too was that they are usually evacuated through the lobby and out to the front porch outside. This reporter's identity was not discussed by the inspectors, but had it been the same as previous discussion, it would not be valid either.
- After an educational discussion with Anne Graziano from the office, we decided to implement evacuating to the designated meeting place which is the farthest parking spot in the lot, each and every drill to ensure sustained compliance and have no confusion for the residents.
- Maintenance Director will also paint a colorful marking on that spot to clearly designate this area, once the weather permits him to do so. This will aide in resident and staff clearly knowing where to evacuate to.
- If our floor staff at the time of this drill only had residents evacuate to the Lobby, our Fire Safety expert and Maintenance Director, Rob Naro would have made them proceed out the door to the proper designated meeting place.
- Maintenance Director and Fire Expert, Rob Naro will continue to enforce this regulation when he pulls unannounced fire drills monthly to ensure sustained compliance going forward.
- ED and/or Designee will monitor for compliance as well.

6-17-19

Chris Murray  
ED.

*[Handwritten signature]*

6/14/19

227d - Support Plan Medical/Dental

Regulations

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. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #1, dated 2/19/19, indicates the resident has a need for wound care. The resident's support plan, dated does not document how this need will be met.

The assessment for resident #2, dated 3/7/19, indicates the resident has a need for physical therapy. The resident's support plan, dated does not document how this need will be met.

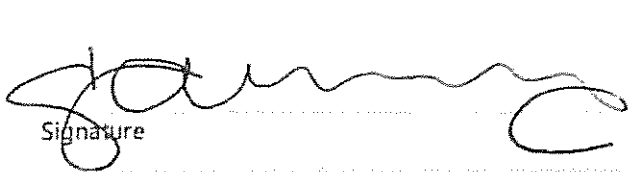
The assessment for resident #3, dated 7/19/18, indicates the resident has a need for physical therapy and occupational therapy. The resident's support plan, dated does not document how this need will be met.

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.)

(See attached)

Legal Entity Representative

  
Signature

Chris Murray, CEO. 6/14/19  
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 6-17-19  
(Date)

Plan of correction implementation status as of 6-17-19  
(Date)

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

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

2600.227 (d)

- Resident Assessments must indicate all the resident's needs and or services and notations must be made timely as noted in the 3 examples given on the violation report.
- The updated RASP addendums for each of the resident's #1, #2 and #3 are attached with the correct and updated notations as required. (See Attachments #7 ((3 pages)), #8, #9(( 2 pages)))
- LPN, Wendy Sebolka, who has been filling in with the absence of an RN or Director of Nursing, was re-trained on this compliance issue by Regional Nurse, Angel Lyles, during our annual internal Enlivant scorecard on 6/4/19.
- Weekly meeting our now set in place with internal Genesis Rehab/Angel's Touch HH, for updating and notating onto the RASP for each current resident being seen.
- RCP's and Med Tech's are also encouraged to report up to the LPN's or CSM any and all needs or concerns of a resident to keep communication flowing both ways. This is done at our daily stand up meetings held at the change of each shift.
- As a double check, we implemented a Skin Audit form this year, completed by the RCP's, once weekly during the resident's shower that documents any new findings on the resident. This is brought to the LPN or CSM for their attention and review.
- CSM/LPN is responsible to ensure sustained compliance.
- ED and/or designee will monitor for compliance as well.

The Administrator will work with the wellness team to ensure that all aspects of care are reviewed in the RASP and there is a plan to assess and plan for the delivery of all resident needs. The wellness team will ensure that communication flows both upwards to the supervisors and management team and well as in the reverse in identifying areas of concerns, new or changing resident needs, and a plan to meet them, including who is responsible for what.

As changes occur, the home will document these updates on the Assessment Addendums (see model form on the Department website.

If the staff need training in order to meet a resident's needs, the home will ensure that the training occurs and is specific to the resident. 11-17-19

AG

6-17-19

Chris Murray  
ED.

*[Handwritten signature]*

6/14/19