October 21, 2019

Ms. Janet Stockhausen
Compliance Officer
Paramount Senior Living at Maytown LLC
3025 Washington Road, Suite 201
McMurray, Pennsylvania 15317

RE: Paramount Senior Living at Lancaster County
2760 Maytown Road
Maytown, Pennsylvania 17550
Certificate #: 333900

Dear Ms. Stockhausen:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 6 and 7, 2019 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

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.

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

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

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *PARAMOUNT SENIOR LIVING AT LANCASTER COUNTY*
License Number: *333900*
Address: *2760 MAYTOWN ROAD, MAYTOWN, PA 17550*
County: *LANCASTER*
Region: *CENTRAL*

Administrator

Name: *Lori Prevost*
Phone: *7174260033*
Email: *JCOX@PARAMOUNTHR ORG*

Legal Entity

Name: *PARAMOUNT SENIOR LIVING AT MAYTOWN LLC*
Address: *3025 WASHINGTON ROAD SUITE 201, MCMURRAY, PA, 15317*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *11/17/1999*
Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *118*
Waking Staff: *89*

Inspection

Type: *Full*
BHA Docket #:
Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

06/06/2019 - On-Site: Douglas Hoover, Kellie Cargile

06/07/2019 - On-Site: Douglas Hoover, Kellie Cargile

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *116*
Residents Served: *83*

Secured Dementia Care Unit

In Home: *Yes*
Area: *300 & 500 Hallways*
Capacity: *44*
Residents Served: *30*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *83*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *35*
Have Physical Disability: *1*

Rec'd
8/01/19
GE

15a - Resident Abuse Report

Regulations

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 5/2/2019, at 9:30 am, Staff Member A witnessed Resident #1 and Resident #2 arguing in their room. Resident #1 was witnessed hitting Resident #2. Resident #1 stated that Resident #2 was hitting and pinching her. Resident #1 was assessed by staff, noting a pea-sized bruise on her left elbow and upper arm.

On 5/20/2019, Residents' #1 and #2 were arguing while walking down the hallway. Resident #1 kicked Resident #2 in the right shin which resulted in a skin tear.

Neither of the incidents were reported to the Lancaster County Area Agency on Aging.

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.)

Both incidents were promptly reported to the Department of Human Services. Physician and responsible parties were notified of incidents. Reports were not made to Older Adult Protective Services in error. In the future, with any resident to resident altercations, community will notify DHS, physician, responsible party, and Older Adult Protective Services. To ensure the deficiency does not occur again, all staff will be inserviced on abuse reporting to all mandatory agencies by Aug 20, 2019. To ensure ongoing compliance, Executive Director will monitor all allegations of abuse for proper reporting monthly.

Legal Entity Representative

[signature] Signature

Lori A. Prevost, Executive Director — Printed Name and Title

8/1/19 — Date

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

The above plan of correction is approved as of 9/18/19 (Date)

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

Plan of correction implementation status as of 9/18/19 (Date)

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

82c - Locking Poisonous Materials

Regulations

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 6/7/2019, there was a container of "Clorox Healthcare Hydrogen Peroxide Wipes" stored in a unlocked cabinet behind the nurse's station in the Secured Dementia Care Unit (SDCU).

Plan of Correction (POC)

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

The container of "Clorox Healthcare Hydrogen Peroxide Wipes" were removed immediately from the unlocked cabinet and locked up. Staff was inserviced on the correct place to store potentially poisonous materials. No products that have a potentially poisonous effect will be stored in unlocked areas. Resident care manager, LPN and Executive Director will monitor ongoing compliance.

Staff will be instructed to check areas of the SDCU for poisonous materials at least once per shift. Any poisonous materials not in use will be made locked and inaccessible to residents immediately. - GE, 9/18/19

Legal Entity Representative

Signature [signature]

Printed Name and Title: Lori A. Prevost, Executive Director

Date: 8/1/19

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

The above plan of correction is approved as of 9/18/19 (Date)

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

Plan of correction implementation status as of 9/18/19 (Date)

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

184b - Resident's Meds Labeled

Regulations

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On 6/7/2019, there was a bottle of Bayer Aspirin, 81 mg. in the bottom drawer of the "Back" medication cart that was not labeled with the resident's name.

Plan of Correction (POC)

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

The bottle of Bayer Aspirin 81 mg was removed immediately from the medication cart and destroyed per policy. We have communicated with families and staff that we no longer accept any medications that are not packaged in the "blister pack" method. We will no longer accept any medications brought from home. An audit of all three medication carts will be completed by Aug 20, 2019 to ensure that there are no medications in the carts that are not packaged correctly. Resident Care Manager, LPN and Assistant Resident Care Manager, LPN will monitor for ongoing compliance with monthly medication cart checks.

Legal Entity Representative

[signature] Signature

Lori A. Prevost, Executive Director — Printed Name and Title

8/1/19 — Date

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

The above plan of correction is approved as of 9/18/19 (Date)

Plan of correction implementation status as of 9/18/19 (Date)

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

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

231b - Medical Evaluation

Regulations

2600.

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

Description of Violation

Resident #3 was admitted to the SDCU on 2/4/2019. The medical evaluation, dated 1/31/2019, does not have a diagnosis of Alzheimer's or dementia but rather "memory loss."

Repeat violation 6/11/2018

Plan of Correction (POC)

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

Resident #3's medical evaluation was immediately corrected with a diagnosis of dementia (Attachment #1). Resident # 3 is on Aricept (Donepezil) and has been on this medication since admission for a diagnosis of dementia (Attachment #2). The diagnosis was not carried over to the medical evaluation.

An audit was done on all resident charts that reside in the SDCU and all residents had a diagnosis of dementia, Alzheimer's, or cognitive impairment as part of their medical evaluation.

(RCM) Resident care Manager, going forward will ensure that a correct diagnosis is put on the medical evaluation for all future admissions. RCM will conduct periodic audits to ensure compliance. The Executive Director will also ensure ongoing compliance with chart audits of all new admissions and annuals.

Legal Entity Representative

Signature: [signature]

Printed Name and Title: Lori A. Prevost, Executive Director

Date: 8/1/19

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

The above plan of correction is approved as of 9/18/19 (Date)

Plan of correction implementation status as of 9/18/19 (Date)

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

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

231e - No Objection Statement

Regulations

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

The home does not have documentation that Resident #3 consented to admission to the SDCU. The consent form used by the home was not signed by Resident #3 and documents the resident's fearfulness of memory care placement.

Plan of Correction (POC)

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

The documentation for Resident #3 initially stated that she refused to sign. This document was corrected on 6/7/19. Executive Director spoke with Resident #3 and explained her living situation and she agreed to sign document (Attachment #3)

An audit was done of all SDCU resident's charts to ensure that all residents and responsible parties completed the Consent for Admission form. All are in compliance.

To ensure ongoing compliance, the marketing manager and Executive Director will make sure that both residents and responsible parties understand and sign the Consent Form for Admission.

Executive Director will periodically audit charts to ensure ongoing compliance.

Legal Entity Representative

[signature] Signature

Lori A. Prevost, Executive Director — Printed Name and Title

8/1/19 — Date

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

The above plan of correction is approved as of 9/18/19 (Date)

Plan of correction implementation status as of 9/18/19 (Date)

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

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

231h - Resident-Home Contact

Regulations

2600.

231.h. The resident-home contract specified in § 2600.25 (relating to resident-home contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Description of Violation

The contract, dated 2/4/2019 for Resident #3, does not specify SDCU services, programming and fees.

Contracts, dated 4/1/2019, 3/9/2018 and 4/19/2018 for SDCU Residents' #4, #5 and #6 respectively, also did not specify SDCU services, programming and fees.

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.)

Paramount Senior Living's Corporate office is developing a disclosure of services, admission and discharge criteria, change in condition policies, special programming, and costs and fees that will be included with the resident home contract for residents that move into the SDCU.
This will be completed by August 28, 2019 and will be implemented for all new admissions into the SDCU beginning on September 1, 2019. A copy of the disclosure statement will be sent to the Department of Human Services on or before August 28, 2019.

Legal Entity Representative

[signature] Lori A. Prevost, Executive Director 8/1/19

Signature — Printed Name and Title — Date

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

The above plan of correction is approved as of 9/18/19 (Date)

Plan of correction implementation status as of 9/18/19 (Date)

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

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

233c - Key-Locking Devices

Regulations

2600.

233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

There were no directions or codes posted for the operation of the SDCU front door and outside courtyard gate keypads.

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.)

During the inspection visit, the directions and codes to the SDCU were not present at the front door and the outside courtyard gate. They were present prior to that time and must have been taken off in error. The directions and codes were immediately put back in those two locations.

The maintanence manager will ensure compliance to this regulation by checking all exit doors on the SDCU on his daily rounds. Executive Director will also ensure ongoing compliance.

Legal Entity Representative

Lori A Prevost
Signature

Lori A. Prevost, Executive Director
Printed Name and Title

8/1/19.
Date

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

The above plan of correction is approved as of 9/18/19 (Date)

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

Plan of correction implementation status as of 9/1819 (Date)

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

234b - Support Plan Needs Elements

Regulations

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The cognitive preadmission screening for Resident #3, dated 2/4/2019, includes agitation under "Behaviors Exhibited" but the support plan, dated 2/6/2019, lists agitation as "Not Applicable."

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.)

Initially, when the prescreen was signed by the physician the family noted to the physician that there had been some agitation noted at her prior residence. Upon admission, no agitation was noted and during the first week of admission and ongoing, no agitation has been noted. On resident #3's RASP, on page 9 (Attachment #4), the Resident Care Manager, LPN added the prior incidences of agitation and we will monitor for any agitation.

Going forward, we will make sure that we are monitoring for signs of any behaviors that are noted on the prescreen. We will monitor and notate on the RASP. Resident Care Manager will ensure compliance upon admission and the Executive Director will do periodic chart reviews.

Legal Entity Representative

Signature: Lori A Prevost
Printed Name and Title: Lori A Prevost, Executive Director
Date: 8/1/19

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

The above plan of correction is approved as of 9/18/19 (Date)

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

Plan of correction implementation status as of 9/18/19 (Date)

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