October 28, 2019

Ms. Diana Ponterio
Senior Vice President of Operations/Regulatory Compliance
The Ecumenical Communities, Inc.
830 Cherry Drive
Hershey, Pennsylvania 17033

RE: Ecumenical Retirement Community of Harrisburg II
601 Wilhelm Road
Harrisburg, Pennsylvania 17111
Certificate #: 362150

Dear Ms. Ponterio:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 10, 2019 and July 1, 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: *ECUMENICAL RETIREMENT COMMUNITY OF HARRISBURG II* **License Number:** *362150*
Address: *601 WILHELM ROAD, HARRISBURG, PA 17111*
County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

Name: *SHELLEY WEIKEL* **Phone:** *7175619982* **Email:** *cbaugher@ecumenicalretirement.org*

Legal Entity

Name: *THE ECUMENICAL COMMUNITIES INC*
Address: *830 CHERRY DRIVE, HERSHEY, PA, 17033*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *02/19/1997* **Issued By:** *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *85* **Waking Staff:** *64*

Inspection

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

Inspection Dates and Department Representative

06/10/2019 - On-Site: Hope O'Pake, Laura Heemer

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served:** *84*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older:** *84*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *1* **Have Physical Disability:** *1*

Rec'd
8/12/19
GE

18 - Compliance With Laws

Regulations

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

There was no carbon monoxide detector located outside of the mechanical room.

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 carbon monoxide detector was immediately placed outside the mechanical room while the inspectors were on-site - June 11, 2019.

Ongoing, maintenance director / designee will monitor to ensure the carbon monoxide detector remains in place outside the mechanical room., and operational. GE - 9/19/19

Legal Entity Representative

Signature

Diana Ponterio, Sr. VP of Ops / Reg Compliance 8/5/19
Printed Name and Title Date

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

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

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

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

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

141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on 3-17-19. The resident's previous medical evaluation was completed on 2-2-18.

Resident #2's most recent medical evaluation was completed on 3-20-19. The resident's previous medical evaluation was completed on 12-18-17.

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.)

Executive director / designee will ensure all residents have a medical evaluation at least annually.

Executive director / designee will conduct random audits to ensure ongoing compliance.

During the audit, if any resident's medical evaluation is overdue, a new evaluation will be scheduled as soon as possible and annually thereafter. - GE, 9/19/19

Legal Entity Representative

Signature: Diana Ponterio [signature]

Printed Name and Title: Diana Ponterio. Sr. VP of Ops / Reg Compliance — Date: 8/5/19

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

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's preadmission screening form, dated 6-20-18, does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #4's preadmission screening form, dated 2-23-18, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction (POC)

While preadmission screening forms were completed for Resident #3 and #4 and the residents needs could be met - staff accidentally missed checking the box that states "needs can be met by the services provided by the home". Resident #3 and #4 prescreens have been amended to reflect that the needs of the resident can be met by the services provided by the home. Staff has been retrained to ensure they check the box that the resident needs can be met.

To ensure ongoing compliance, the executive director / designee will conduct random audits to ensure prescreens are completed properly.

Executive director / designee will monitor to ensure the areas are completed to signify if the needs can be met by the services provided by the home. This will be monitored for all new residents moving in to the home.

Legal Entity Representative

Signature

Diana Ponterio, Sr VP of Ops / Reg Compliance 8/5/19
Printed Name and Title Date

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Violation Report

Facility Information

Name: *ECUMENICAL RETIREMENT COMMUNITY OF HARRISBURG II* **License Number:** *36215*
Address: *601 WILHELM ROAD, HARRISBURG, PA 17111*
County: *DAUPHIN* **Region:** *CENTRAL*

Administrator

Name: *Shelley Weikel* **Phone:** *7175619982* **Email:**

Legal Entity

Name: *THE ECUMENICAL COMMUNITIES INC*
Address: *830 CHERRY DRIVE, HERSHEY, PA, 17033*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *92* **Waking Staff:** *69*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Incident*

Inspection Dates and Department Representative

07/01/2019 - On-Site: Kellie Cargile

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *104* **Residents Served:** *84*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *13* **Are 60 Years of Age or Older:** *84*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *8* **Have Physical Disability:** *1*

Rec'd
8/12/19
GE

225c - Additional Assessment

Regulations

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's most recent assessment, dated 12/6/18, indicated that he/she was independent with transferring to and from bed and chair. On the following dates, Resident #1 had unwitnessed falls in his/her bedroom while trying to get out of bed or maneuver around the room: 12/17/18, 1/13/19, 3/17/19, 3/20/19, 3/21/19, 3/22/19, 3/23/19, 4/18/19, 4/28/19, 5/10/19, 5/13/19, and 6/4/19. Resident #1 did not have a new assessment to reflect the assistance needed for transferring.

Plan of Correction (POC)

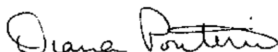
(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Resident #1 assessment / support plan reflects that the plan was updated using the DHS Assessment & Support Plan updates and changes form after each fall with an intervention to assist Resident #1. Resident #1 was educated on using the call bell to get assistance with transferring from her bed and chair. In the future a new RASP will be completed when a resident is no longer independent with transfers.

Ongoing, executive director / designee will randomly audit assessments to ensure compliance.

Any plan found to be in need of an update during the audits shall have one completed immediately - GE, 9/19/19.

Legal Entity Representative



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Diana Ponterio, Sr. VP of Ops / Reg Compliance 8/5/19
Printed Name and Title Date

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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

Resident #1 was receiving physical therapy and occupational therapy from 5/17/19 to 6/3/19. The resident's support plan, dated 12/6/18, did not document the need for or frequency of these services, nor was it updated by the home.

Plan of Correction (POC)

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

Resident #1 support plan was updated using the DHS Assessment and Support plan updates and changes form on 12/17/2018 to include orders obtained for PT/OT. Staff completing the RASP will be retrained on proper procedures for completing the RASP by end of August 2019.

Ongoing executive director / designee will conduct audits to ensure compliance.

Legal Entity Representative

[signature]
Signature

Diana Ponterio, Sr. VP of Ops / Reg Compliance 8/5/19
Printed Name and Title Date

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