



MAILING DATE: September 11, 2019

Mr. David Paveletz
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
Certificate #: 332100

Dear Mr. Paveletz:

As a result of the Department's Bureau of Human Services Licensing inspection on July 11, 2019 of the above facility, the citations 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.

Sincerely,

Gloria Emick

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL*
Address: *1775 POWDER MILL ROAD, YORK, PA 17403*
County: *YORK* Region: *CENTRAL*

License Number: *33210*

Administrator

Name: *Jeremy Keiter* Phone: *7177410961* Email: *jkeiter@HERITAGESL.COM*

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*
Address: *765 SKIPPACK PIKE SUITE 300, BLUE BELL, PA, 19422*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: Issued By:

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *129* Waking Staff: *97*

Inspection

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

Inspection Dates and Department Representative

07/11/2019 - On-Site: Kellie Cargile, Laura Heemer

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* Residents Served: *96*

Secured Dementia Care Unit

In Home: *Yes* Area: *Arlington and Rosewood Neighbors* Capacity: *28* Residents Served: *26*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *96*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33* Have Physical Disability: *0*

Rec'd
8/8/19
GE

07/11/2019

1 of 3

54a - Direct Care Staff

Regulations

2600.

54.a.2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct Care Staff Person A, hired 6/12/19, does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

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.)

Immediate Action: The community self-identified the non-compliance with regulations pertaining to 2600.52(a) and already had staff member A on suspension at the time of the inspection. This was due to her not being able to provide her diploma or GED. Her diploma was obtained 7/12/19 which was within 24 hours of the identified documentation gap found during the inspection on 7/11/19. Staff member A was reinstated upon receipt of the diploma. Please see attached documentation.

Audit Action: An audit was conducted following the inspection and no other gaps in documentation corresponding to 2600.52(a)(2) were identified.

Training Action: All hiring supervisors and office staff will be retrained on the items needed for team members prior to employment including those pertaining to 2600.52(a)(2). This training will be completed by Doug Fouché, Executive Director, by 8/9/19. Moving forward, all new supervisors and office staff will receive this training from the administrator or designee. Documentation of the training of current staff is attached.

Monitoring Action: The administrator or designee will review all team members personnel files at least quarterly to ensure compliance with 2600.52(a)(2) and review in the quarterly QA meeting.

Legal Entity Representative

Signature 

Printed Name and Title *Doug Fouché Executive Director*

Date *8/8/2019*

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

The above plan of correction is approved as of 9/10/19 (Date) Plan of correction implementation status as of 9/10/19 (Date)

The above plan of correction was approved by GE (Initials) Fully Implemented Partially Implemented - Adequate Progress Partially Implemented - Inadequate Progress Not Implemented

225c - Additional Assessment

Regulations

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

Resident #1's most recent assessment was completed on 2/22/19. On 5/31/19, Resident #1 was diagnosed with dysphagia and ultimately admitted to hospice on 6/5/19. Resident #1 did not have a new assessment that documented the resident's change in medical condition or need for hospice services.

Plan of Correction (POC)

(/ **Immediate Action:** Resident #1 passed away on June 15, 2019. Since she is no longer a resident the creation of a new RASP is now moot.

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Audit Action: An audit was conducted by the Executive Director 8/1/19 of the documents pertaining to 2600.225(c). During this initial audit, the Executive Director found a number of gaps in documentation including preadmission screens, 2600.224(a-c); medical evaluations, 2600.141(a-b) and resident assessment and support plans, 2600.225(a-c). This initial audit was halted, and a plan established to provide for a comprehensive audit of all resident records, including updates as required, which will be completed by the administrator or designee on or before 9/13/19.

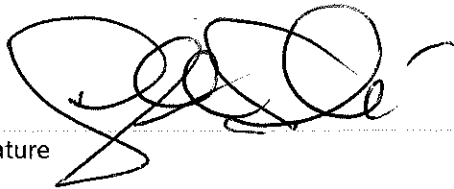
Personnel Change: The Resident Care Director responsible for the non-compliance with required resident documentation is no longer employed by the community.

Procedural Change: The community has now hired two additional staff, with one more in the hiring pipeline, to supplement those already involved with resident documentation including those required by 2600.225(c), as well as the resident documentation pertaining to the regulations cited above in the Audit Action section. This will ultimately allow for four LPN's and RN's to manage this important resident support and compliance function.

Training Action: Training of all staff noted above will be conducted by Doug Fouché, Executive Director, by 8/16/19. This training will include ongoing maintenance of the community RASP's as well as utilizing tools in the Tabula Pro system to ensure timely and accurate completion of said documents. Documentation of the training will be provided to the Bureau upon completion.

Monitoring Action: The administrator or designee will review all new resident files, as well as those being updated, at least monthly to ensure compliance with 2600.225(c). This will also include the other resident documentation pertaining to the regulations cited above in the Audit Action section and will be reviewed in the quarterly QA meeting.

Legal Entity Representative



Signature

Doug Fouché Executive Director

Printed Name and Title

Date

8/8/2019

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- Partially Implemented - Inadequate Progress
- Not Implemented