pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **NORTH WALES 1089 MC BG OPCO LLC**
LEGAL ENTITY

To operate **PARK CREEK PLACE - MEMORY CARE**
NAME OF FACILITY OR AGENCY

Located at **1089 HORSHAM ROAD, NORTH WALES, PA 19454**
(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

PROVISIONAL

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 **48**
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller
(MAXIMUM CAPACITY)

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 48**

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 **November 7, 2019** until **May 7, 2020**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142561**

Robert E. Robinson
ISSUING OFFICER

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.

HS 628p – 7/19

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: November 7, 2019

Mr. Matthew Coleman
Authorized Signatory
North Wales 1089 MC BG OPCO, LLC
330 North Wabash Avenue, Suite 3700
Chicago, Illinois 60611

RE: Park Creek Place – Memory Care
1089 Horsham Road
North Wales, Pennsylvania 19454
Certificate #: 142561

Dear Mr. Coleman:

As a result of the Department's Bureau of Human Services Licensing inspection on April 16, 2019, April 17, 2019, May 16, 2019, July 1, 2019 and July 9, 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 # 142560 dated November 1, 2019 to November 1, 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 November 1, 2019 to November 1, 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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa.Code §§ 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa.Code Chapter 2600 Section no.	Class of Violation	Census at Inspection X	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
65a	II	42	$5	$210	5 calendar days from mailing date of this letter
65f	III	42	$3	$126	15 calendar days from mailing date of this letter
187d	II	42	$5	$210	5 calendar days from mailing date of this letter
227g	III	42	$3	$126	15 calendar days from mailing date of this letter

A fine will be assessed on a daily basis beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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:

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,

Kevin Hancock
Deputy Secretary
Office of Long-Term Living

Enclosures
License
Violation Report

Violation Report

Facility Information

Name: *PARK CREEK PLACE MEMORY CARE* License Number: *142560*
Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: *Monica Bera* Phone: *2155400520* Email: *rwinslow@enlivant.com*

Legal Entity

Name: *NORTH WALES 1089 MC BG 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: *80* Waking Staff: *60*

Inspection

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

Inspection Dates and Department Representative

04/16/2019 - On-Site: Denise Gillespie, Joseph Eveges

04/17/2019 - On-Site: Denise Gillespie, Joseph Eveges

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* Residents Served: *40*

Secured Dementia Care Unit

In Home: *Yes* Area: *The whole building* Capacity: *48* Residents Served: *40*

Hospice

Current Residents: *10*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *40*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *40* Have Physical Disability: *18*

42b - Abuse

Regulations

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 3/21/19 Resident #1 eloped from the home in the morning around 9:05 A.M. and crossed a 4 lane highway before a Staff Member C found the resident at the corner of Hartman Road and Horsham Road. The resident was able to elope because the exit door was not reset following an overnight fire drill on 3/21/19 at 2:51 A.M. The resident was exit seeking numerous times during that morning. The resident set off the door alarm 15 times before successfully exiting. Staff were aware Resident #1 was exit seeking because they heard the alarm each time Resident # 1 touched the door. Staff should have responded each time the alarm went off and redirected the resident to prevent the elopement.

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 elopement risk assessment reevaluated on 3/21/19, Enlivant leveling tool/ assessment updated on 5/1/19, support plan updated on 5/20/19.
- Elopement training completed 3/27/19; attendance sheet attached (page 1a and 1b)
- Elopement drills conducted on each shift during the week following incident as additional training/practice for staff. Conducted 8 elopement drills through 3/27/19 on both shifts.
- residents assessed quarterly for elopement risk.
-high risk elopement residents in binder at front desk.
-Elopement drills to be conducted at least monthly on alternating shifts by ED or designee, monitoring ongoing, compliance to be determined thru QA process.

Please see attached.......

Legal Entity Representative

Signature — Richard M. Winslow AED — 7/16/19

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 08-24-19 (Date)

Plan of correction implementation status as of 08-24-19 (Date)

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

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

2600.42b

Home did provide verification that elopement training was conducted with staff members on 03-27-19. Within 30 days receipt of POC all residents elope risk assessments will be updated and documented in RASP. All memory care doors will always be locked. Administrator or designated person will perform daily walkthroughs of facility to ensure doors are locked and functional. Staff will respond to alarms whenever they are activated to ensure resident safety.

SP 08-24-19

Documentation of the daily walkthroughs shall be maintained for Department review. SMP 10/18/19

54a - Direct Care Staff

Regulations

2600.
54.a. Direct care staff persons shall have the following qualifications:

1. Be 18 years of age or older, except as permitted in subsection (b).
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.
3. Be free from a medical condition, including drug or alcohol addiction, that would limit direct care staff persons from providing necessary personal care services with reasonable skill and safety.

Description of Violation

Direct care Staff Person A, 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.)

-Staff person A diploma filed in employee file.
- current employee files audited 5/6/19 for high school diploma, GED or current registry on the PA nurse aide registry, see attached employee file audit (page 2c).
- Employees without diploma or current registry on the PA nurse aide registry removed from schedule, not permitted to work until documentation obtained. Updated employee file audit attached (see page 2d)
- Administrator trained on regulation on 4/26/19 by Penn State.
-Business office manager trained on regulation 2600.54a by Administrator on 7/10/19, see attached training record (page 2a and 2b).
- Business office manager to audit potential new hires prior to offer to ensure potential employee is compliant with regulation 2600.54.a See attached Pre Hire Checklist (page 3) to be completed by Business office manager or designee on potenial new hire applicants.
- Monitoring to be ongoing; compliance to be determined thru QA process.

Please see attached......

Legal Entity Representative

[signature] Richard M. Winslow AED 7/16/19

Signature — Printed Name and Title — Date

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2600.54 a

The administrator or designee will review all current direct care staff records to ensure all direct care staff persons meet the qualifications in accordance with regulation 2600.54(a), within 30 days receipt of this POC. Documentation will be kept in the staff records for Department review. Only those staff persons who meet the direct care staff qualifications will provide direct care services. Home did provide verification of Staff member A's qualifications.

SP 08-24-19

65a - FS Orientation 1st Day

Regulations

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was 7/18/18, and staff person C whose first day of work was 12/19/18, did not receive orientation on the following topics:
1. Evacuation procedures 2. Staff duties during fire drills 3. Designated meeting place
4. Smoking safety procedures 5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.

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.)

-staff person B and C trained 6/18/19
- current employee files audited; see attached employee file audit (page 2c); employees trained on topics in regulation 2600.65a. See attached sign in record (page 4a-h). Employee file audit updated, see attached (page 2d)
- current administrator trained on this requirement on 4/26/2019 by Penn State.
-Administrator or designee will review new employee files for compliance prior to completion of orientation process; see attached new employee file audit (page 5)
- Monitoring will be ongoing; compliance to be determined in QA process.

Please see attached......
repeat violation 08/13/18

Legal Entity Representative

M Winslow
Signature

Richard M. Winslow AEO
Printed Name and Title

7/16/19
Date

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

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

2600.65 (a)

Administrator or designee will ensure all direct care staff persons including ancillary staff persons, substitute personnel, and volunteers have a general fire safety and emergency preparedness training that covers all the aspects of 2600.65(a) prior to their first day of work. Record of training to be kept by home and made available for Department review. Home provided verification Satff persons B and C did receive training in 2600.65 a. Audit of all staff members records to be completed within 30 days receipt of POC to ensure all training complete.

SP 08-24-19

65d - Initial Direct Care Training

Regulations

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care Staff Person A, hired on 5/21/18, began providing unsupervised ADL services on 5/21/18. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

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.)

- Staff person A completed department-approved direct care training course and passed on 4/18/19, copy in file.
- current employee files audited 5/6/19, see attached employee file audit (page 2c)
- current employees who have not completed the Department -approved direct care training course and passed the competency test have been removed from the schedule until documentation provided. Employee training file audit updated, see attached (page 2d).
- current administrator trained on this requirement on 4/26/2019 by Penn State
- Administrator or designee to audit new hire files, see attached new employee training audit (page 5)
- monitoring to be ongoing; compliance to be determined in the QA process.

Administrator or designee will ensure all direct care staff persons have training that covers all the aspects of 2600.65(d) prior to providing unsupervised ADL services. Record of training to be kept by home and made available for Department review. Home provided verification Satff person A did receive training in 2600.65 d. Audit of all direct care staff members records to be completed within 30 days receipt of POC to ensure all training complete. SP 08-24-19

Legal Entity Representative

M Winslow
Signature

Richard M. Winslow AED
Printed Name and Title

7/16/19
Date

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141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident # 1's medical evaluation dated 12/07/18, did not include the residents ability to administer medications.

Resident # 2's medical evaluation dated 02/09/19, did not include the date the resident was evaluated and the second page of the form.

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 DME corrected via verbal order from physician; resident may not self administer medications.
-Resident #2 is no longer a resident at Park Creek Place Memory Care.
- current resident files audited; as of May 30, 2019 current residents compliant with regulation. See attached audit/tickler file maintained by CSM (page 6d and 6e)
- Current Administrator trained on requirement on 4/26/2019 by Penn State.
- CSM trained on regulation 2600.141.a on 7/10/2019 by Divisional Care Services Specialist. (See page 6a,b,c)
-Administrator or designee to audit new admissions for proper DME completion; see attached Admission Audit (see page 7). Monitoring will be ongoing, compliance will be determined thru QA process.

Legal Entity Representative

please see attached
repeat violation 08/13/18

[signature]
Signature

Richard M Winslow AED 7/16/19
Printed Name and Title Date

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2600.141 a

Within 30 days receipt of POC, the administrator or designated staff person will review all current medical evaluations to ensure medical evaluations are completed timely, accurately and in their entirety to include a medication regimen. Any incomplete medical evaluations will be returned to the physician for completion or new in-person medical evaluations will be scheduled and completed.

SP 08-24-19

187a - Medication Record

Regulations

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.

Description of Violation

Resident # 1 is prescribed morphine sulfate solution. However, Resident # 1's medication administration record does not include this medication.

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 order for Morphine discontinued on 4/22/19 by physician.
- Medication techs and nurses inserviced regarding appropriate medication administration on 5/23/19; see attached training record (page 8a,b,c).
- Medication Order Audit began 5/29/19 to ensure orders written are transcribed and checked by 2 staff members. (See attached page 9)
-CSM responsible for sustained compliance; CSM and ACSM will continue Medication Order Audit. Monitoring will be ongoing, compliance will be determined thru QA process.

Immediately: A staff person qualified to administer medications will conduct an initial and monthly review of all current resident MARs and prescriber's orders to insure all prescribed medications are documented on the resident's MAR's in accordance with regulation 2600.187(a). Home did provide verification med techs and nurses were trained on medication administration records on 05-23-19.

SP 08-24-19

Legal Entity Representative

Signature: [signature]

Printed Name and Title: Richard M. Winslow AED

Date: 7/16/19

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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 #2's preadmission screening form, dated 2/7/19, does not include supervision needs and 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.)

- Resident #2 no longer resides in the community.
- Resident records audited for prescreen completion on 6/19/19, see attached audit (page 10e).
- CSM was trained on regulation 2600.224a on 5/13/19; (see attached training record page 10a,b,c,d)
-CSM is responsible for sustained compliance. The administrator or designee will audit for the preadmission screening form to ensure completion prior to move in; see attached Admission Audit. (See page 7)
- Monitoring will be ongoing, compliance to be determined thru QA process.

Monitoring and audits of prescreen completion to be maintained by home and made available for Department Review. Administrator or designated staff person will ensure all new residents have a preadmission screening form completed within 30 days prior to admission. Home did provide verification of audit on 06-19-19 and training on 05-13-19.

SP 08-24-19 repeat violation 08/13/18

Legal Entity Representative

M Winslow
Signature

Richard M. Winslow AEO
Printed Name and Title

7/16/19
Date

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225a - Assessment 15 Days

Regulations

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident # 1's assessment, dated 12/22/18, does not include pages 3, 4, 5, 6, 7, 8, 9, 10, and 11.

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's partially implemented RASP can not be altered or completed. Resident #1 has a completed RASP on filed as of 5/20/2019.
-Active resident charts audited for assessement and support plans (RASPs). RASPs completed on current residents as of May 30th. See attached audit/tickler file maintained by CSM (page 6d and 6e).
- CSM trained on proper completion of RASP on 5/13/19; see attached training record (page 11a-11d)
- Administrator trained on regulation on 4/26/19 by Penn State.
-Admission audit began 5/22/19, see attached (page 7); completed by Administrator of designee, monitoring to continue, compliance to be determined via QA process.

Administrator or designee will ensure all Resident Assessment Support Plans (RASP), are completed within timeframes specified in 2600.225a. Within 30 days receipt of this POC all RASP will be audited to ensure they are updated to reflect residents needs. Home did send in verification CSM was trained on RASP 05-13-19. Documentation of all trainings, audits, and monitoring will be maintained by home and made available for Department review.

SP 08-24-19 repeat violation 08/13/18

Legal Entity Representative

R. M. Winslow
Signature

Richard M. Winslow AED
Printed Name and Title

7/16/19
Date

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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

The directions for operating the home's locking mechanism are not conspicuously posted near the south wing door to the Secure 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.)

- walk thru performed; directions replaced to South Wing door and to front lobby door key pad areas.
- Current administrator trained on regulation 4/26/19 by Penn State.
- Program Manager trained on regulation 2600.233.c by Administration on 7/10/19, see attached (page 13a, b and c).
- Daily walk thru rounds to be completed by Program Manager to ensure compliance to be communicated during daily stand up meeting with ED and administrative team.

The administrator or designated staff person will monitor the SDCU at least weekly to ensure the directions for the operation of the keypad system are conspicuously posted near the device.

SP 08-24-19

Legal Entity Representative

Signature	Printed Name and Title	Date
[signature]	Richard M. Winslow AED	7/16/19

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Violation Report

Facility Information

Name: *PARK CREEK PLACE MEMORY CARE* **License Number:** *142560*
Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*
County: *MONTGOMERY* **Region:** *SOUTHEAST*

Administrator

Name: *Richard Winslow* **Phone:** *2155400520* **Email:** *rwinslow@enlivant.com*

Legal Entity

Name: *NORTH WALES 1089 MC BG OPCO LLC*
Address: *330 N WABASH AVENUE,SUITE 3700, IL, 60611*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *84* **Waking Staff:** *63*

Inspection

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

Inspection Dates and Department Representative

05/06/2019 - On-Site: Michele Swisher

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *42*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire Home* **Capacity:** *48* **Residents Served:** *42*

Hospice

Current Residents: *nm*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *42*
Diagnosed with Mental Illness: *4*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *42*
Have Physical Disability: *0*

25b - Contract Signatures

Regulations

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated 2/13/19, for resident #1 was not signed by the resident and there are no documented attempts to have resident sign or notation of residents inability to sign.

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, reapproached; unable to sign contract due to cognitive deficit, notation made on contract.

- On 6/11/2019, active resident files audited per previous plan of correction. All active resident files compliant to date.

- Admission Audit of resident files to be completed on day of admission (see attached A) initiated 5/22/2019, to be completed X 12 weeks, audit to be completed by administrator or designee.

- ED responsible for contract signing, trained on regulation 2600.25(b) by [redacted] RN,DCSS on 6/19/2019.

- Compliance date: 6/19/2019

Please see attached...........

Legal Entity Representative

[signature]	Richard M. Winslow	6/20/19
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 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.25b

The home will document attempts to have resident #1sign their contract immediately. The administrator will develop a checklist to use in individual resident files. A designee will be trained on the processing of resident contracts within 15 days receipt of this POC.

SP 08-07-19

Documentation of training shall be maintained for Department review. SMP 10/18/19

65a - FS Orientation 1st Day

Regulations

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A who is an agency staff person, whose first day of work was 05/01/19, did not receive orientation in any of the topics specified in 2600.65(a). Repeat Violation - 8/13/18

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- Staff person A trained on topics specified in 2600.65(a) on 5/7/19 (See Attached B). Staff person A as well as other Agency associates were trained on 2600.65(a). As of 5/20/2019, all agency personel used by Park Creek Memory Care are complaint with regulation 2600.65(a).
- Agency orientation training to be completed by all agency staff members prior to or during the first working day.
- Compliance to be monitored by CSM or designee during scheduling process for 12 weeks.
-CSM and ACSM responsible for agency staffing, CSM and ACSM trained on regulation 2600.65(a) by [redacted] RN, DCSS on 6/19/2019.
- Compliance date: 6/19/2019

Please see attached..........

repeat violation [redacted] 08/13/18

Legal Entity Representative

Signature: [signature]

Richard M. Winslow
Printed Name and Title

6/20/19
Date

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

The above plan of correction is approved as of 08-07-19 (Date)

Plan of correction implementation status as of 08-07-19 (Date)

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

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

2600.65(a)

Administrator or designee will ensure all direct care staff persons including ancillary staff persons, substitute personnel, and volunteers have a general fire safety and emergency preparedness training that covers all the aspects of 2600.65(a) prior to their first day of work. Record of training to be kept by home and made available for Department review.

SP 08-07-19

183e - Storing Medications

Regulations

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 5/6/19 4 loose pills were found in the South medication cart.
On 5/6/19 on the North medication cart there was 1 loose pill found, a bottle of Prosource was leaking brown sticky liquid into the cart drawer and a bottle of liquid guaifenesin was leaking red sticky liquid. There was also a collection of small white beads that appear to be Depakote sprinkles that have spilled from a package, present in the drawer of the medication cart.

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.)

- 4 loose pills on south medication cart were removed at time of survey. Loose pill on North cart removed at time of survey as well as bottle of prosource and qualfenesin cleaned, white beads removed from/cleaned from drawer of med cart. Medication carts thoroughly cleaned by LPN following day of survey.

-North and south medication carts thoroughly cleaned and medication cart review (see attached C) initiated on May 22.

- Medication cart review/audit to continue X12 weeks to ensure compliance, monitoring will be completed by CSM or designee.

-CSM and ACSM trained on regulation 2600.183(e) by [redacted] RN, DCSS on 6/19/2019.

-Compliance date: 6/19/2019

Please see attached........
repeat violation - 08/13/18

Legal Entity Representative

Signature: [signature] | Printed Name and Title: Richard M. Winslow | Date: 6/20/19

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

The above plan of correction is approved as of 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.183 e

Within 30 days receipt of POC all medication administration staff will be trained on storing prescription medications in an organized manner in accordance with manufacturer's instructions. Documentation to be maintained by home for Department review. Audits of med carts to be documented for Department review.

SP 08-07-19

185a - Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed Muscle Rub- apply to right abd. 3 times a day as needed for pain and Acetaminophen 325mg take two tablets by mouth every 6 hours as needed for mod to severe pain. On 5/6/19 these medication(s) were not available in the home.

Resident #2 is prescribed Docusate Sodium 100 mg-- One by mouth every day if needed for no bowel movement in three days, Senna 8.6mg- two tabs by mount at bed time as needed for constipation and Icy Hot Cream- Apply to left elbow four times daily as needed for pain. On 5/6/19 these medication(s) were not available in 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 muscle rub and acetaminophen were ordered and received from the pharmacy day of survey. Resident #2 Docusate Sodium, Senna and Icy Hot were ordered and recieved from the pharmacy day of survey.
- CSM or designee will audit 5 residents weekly to ensure compliance for 12 weeks (see attached "D" medication cart audit tool).
- CSM and ACSM trained on regulation 2600.185(a) on 6/19/2019 by [redacted] RN, DCSS.
- Compliance date: 6/19/2019

Please see attached.......

Legal Entity Representative

Signature

Richord M. Winslow
Printed Name and Title

6/20/19
Date

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

The above plan of correction is approved as of 08-07-19 (Date)

Plan of correction implementation status as of 08-07-19 (Date)

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

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

2600.185(a)

Within 30 days receipt of POC, administrator or designee will ensure the home has developed and implemented procedures for safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons. Policies and procedures to be accessible to representatives of the Department at all times. Staff that handle or administer medications and medical equipment will be trained and familiar with policies and procedures. Medication will be accounted for at all times.

SP 08-07-19

187b - Date/Time of Medication Admin.

Regulations

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Mirtazapine 45mg- one by mouth at bedtime. Resident #2's medication administration record does not include the initials of the staff person who administered Mirtazapine on 5/5/19 at 8:00 pm .

Resident #2 is prescribed Olanzapine 15mg one by mouth every morning and at bed time. Resident #2's medication administration record does not include the initials of the staff person who administered this medication on 5/5/19 at 8:00 pm

Resident #2 is prescribed Risperidone 4mg- one by mouth twice daily. Resident #2's medication administration record does not include the initials of the staff person who administered this medication on 5/5/19 at 8:00 pm

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 #2 MAR documentation for May 2019 has been reviewed. Staff person administering medication counciled on timely, accurate documentation of medication administration.

- On May 22, 2019, MAR check audit (see attached E) initiated; completed by med tech/LPN to audit previous shift MAR documentation.

-Audit to continue X 12 weeks to ensure compliance. CSM or designee responible for ongoing compliance.

- CSM and ACSM trained on regulation 2600.187(b) on 6/19/2019 by [redacted] RN, DCSS.

- Compliance date: 6/19/2019

Please see attached.........

Legal Entity Representative

M. Winslow	Richard M. Winslow	6/20/19
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 08-07-19 (Date)

Plan of correction implementation status as of 08-07-19 (Date)

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

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

2600.187(b)

Immediately, the administrator or designee qualified to administer medications will complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with the regulation. Staff will be trained within 15 days receipt of this POC on documentation on MARs. Training to be kept for Department review.

SP 08-07-19

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #3 is prescribed BZA Antifungal cream 2% Apply twice a day to groin for rash and Eucerin Cream apply twice daily to legs and feet. However, this medication was not administered to resident #3 on 5/3/19 on the 7a -7p shift.

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.)

-Staff member administering medications on May 3, 2019 received counciling for failure to complete medication administration.

-On May 22, 2019, MAR check audit initiated; to be completed by med tech/LPN to audit previous shift MAR documentation.

- Audit to continue X 12 weeks to ensure compliance. CSM or designee responsible for ongoing compliance.

-CSM or ASCM trained on regulation 2600.187(d) on 6/19/2019 by [redacted] RN, DCSS.

- Compliance date: 6/19/2019

Please see attached.

repeat violation - 08/13/18

Legal Entity Representative

[signature]	Richard M. Winslow	6/20/19
Signature	Printed Name and Title	Date

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

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.187 d

Within 30 days receipt of this POC, the administrator or designee qualified to administer medications shall complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b). All training and audit documentation to be maintained by home for Department review.

SP 08-07-19

227g -Support Plan Signatures

Regulations

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1's assessment and support plan dated 2/12/19 is not signed by anyone who participated in the development of the plan.

Resident #4's assessment and support plan dated 2/4/19 is not signed by anyone who participated in the development of the plan.

Resident #5's assessment and support plan dated 3/15/19 is not signed by anyone who participated in the development of the plan.

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.)

- All active resident charts audited for assesment and support plans.Assessment and support plans completed for all residents as of May 30th.

- On 5/13/19, new CSM was trained on proper completion of RASP's.

- Administrator trained on completion of RASPs on 4/26/2019.

- Admission audit began 5/22/2019 (see attached E) completed by Adminlstor or designee to continue X 12 weeks to ensure compliance.

- Administrator trained on regulation 2600.227(g) on 6/19/2019 by [redacted] RN, DCSS.

- Compliance date: 6/19/2019

Please see attached......

repeat violation - 08/13/18

Legal Entity Representative

M. Winslow
Signature

Richard M. Winslow
Printed Name and Title

6/20/19
Date

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

The above plan of correction is approved as of 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.227 g

Within 30 days receipt of this POC, administrator or designated staff person will review all current and newly completed support plans to ensure completion including signatures of those involved in the development of the plan. All staff persons involved with the completion of support plans will be educated on the proper completion of support plans including the required signature of persons involved with the development of support plans. Documentation of education will be kept for Department review.

SP 08-07-19

227h - Support Plan Refuse Sign

Regulations

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #1's assessment and support plan dated 2/12/19 is not signed by the resident and there is no mark or indication of the residents inability to sign.

Resident #4's assessment and support plan dated 2/4/19 is not signed by the resident and there is no mark or indication of the residents inability to sign.

Resident #5's assessment and support plan dated 3/15/19 is not signed by the resident and there is no mark or indication of the residents inability to sign.

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.)

- All active resident charts audited for assesment and support plans. Assessment and support plans completed for all residents as of May 30th.
- On 5/13/19, new CSM was trained on proper completion of RASP's.
- Administrator trained on completion of RASPs on 4/26/2019.
- Admission audit began 5/22/2019, completed by Administor or designee; to continue X 12 weeks to ensure compliance.
- Administrator trained on regulation 2600.227(h) on 6/19/2019 by [redacted] RN, DCSS.
- Compliance date: 6/19/2019

Please see attached.......... repeat violation 08/13/18

Legal Entity Representative

[signature]	Richard M. Winslow	6/20/19
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 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.227 h

Immediately the administrator or designee will review all RASP to ensure they are signed or a notation of inability or refusal to sign is documented. Staff who participate in completion of RASP will be educated on signatures. Documentation to be kept for Department review.

SP 08-07-19

231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 01/15/2018. However, the resident's written cognitive preadmission screening was completed on 02/23/18.

Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on 03/15/19. However, the there was no written cognitive preadmission screening completed.

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 #4 cognitive screen cannot be corrected. Resident #5 prescreen unable to be located in resident's chart; prescreen and cognitive screen completed 6/14/2019.

- Active resident files audited; all files compliant as of 6/19/2019.

-On 5/13/2019, new CSM trained on proper completion of prescreen.

- Administrator trained on prescreen regulation on 4/26/2019.

- Admission Audit completed by Adminisitrator or designee X12 weeks to monitor completion of prescreens.

- Administrator trained on regulation 2600.231(c) on 6/19/2019 by [redacted] RN,DCSS.

- Compliance date: 6/19/2019

please see attached...

Legal Entity Representative

Signature: [signature]

Printed Name and Title: Richard M. Winslow

Date: 6/20/19

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

The above plan of correction is approved as of 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.231 c

Immediately - The administrator or designated staff person will review all new resident admissions to ensure a written cognitive preadmission screening is completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form for each resident within 72 hours prior to admission to the secured dementia care unit.

SP 08-07-19

PARK CREEK PLACE MEMORY CARE 142560

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

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 2/13/19.
Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 1/15/18.
Resident #5 was admitted to the Secure Dementia Care Unit (SDCU) on 3/15/19.

The home has no documentation for residents #1, #4, and #5 that the resident and the resident's designated person have not objected to the admission.

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.)

- Current resident files audited on 6/11/19 for objection addendums.
- Objection addendums to be reviewed with resident and resident's designated person within next 30days to ensure compliance with regulation.
- Administrator or designee will ensure compliance by auditing new resident files for completion on day of admission.
- Admission Audit will continue X 12 weeks to ensure compliance. Documentation of audits shall be maintained for Department Review. SMP 10/18/19
- Administrator trained on regulation 2600.231(e) on 6/19/2019 by [redacted] RN, DCSS.
- Compliance date: 7/19/2019

Please see attached..........

Legal Entity Representative

[signature]	Richard M. Winslow	6/20/19
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 08-07-19 (Date)

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

Plan of correction implementation status as of 08-07-19 (Date)

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

2600.231 e

Immediately - The administrator or designee shall review all current secure dementia care resident's records to ensure each resident record has 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.

SP 08-07-19

Violation Report

Facility Information

Name: *PARK CREEK PLACE MEMORY CARE*
License Number: *14256*
Address: *1089 HORSHAM ROAD, NORTH WALES, PA 19454*
County: *MONTGOMERY*
Region: *SOUTHEAST*

Administrator

Name: *Richard Winslow*
Phone: *2155400520*
Email: *rwinslow@ENLIVANT COM*

Legal Entity

Name: *NORTH WALES 1089 MC BG OPCO LLC*
Address: *330 N WABASH AVENUE SUITE 3700, CHICAGO, IL, 60611*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *07/19/1996*
Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *72*
Waking Staff: *54*

Inspection

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

Inspection Dates and Department Representative

07/01/2019 - On-Site: Youn Hie Chung, Jennie Heinberg

07/09/2019 - On-Site: Youn Hie Chung, Jennie Heinberg

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48*
Residents Served: *36*

Secured Dementia Care Unit

In Home: *Yes*
Area: *all*
Capacity: *48*
Residents Served: *36*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *36*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *36*
Have Physical Disability: *0*

3c - Post Current License

Regulations

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 07/01/2019 the home did not post its most recent licensing inspection summary report and a copy of 55 Pa. code 2600 in a conspicuous and public place.

Plan of Correction (POC)

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

On 7/9/19 at time of survey, ED posted most recent licensing inspection summary report and a copy of 55 Pa code 2600 at the front desk.
ED trained regarding posting the current inspection summary report and a copy of 55 Pa code 2600 in a conspicuous and public place. Administrator credentials posted in survey binder.
ED and/or designee will complete weekly audit for 4 weeks, then monthly audit for 2 months to ensure current inspection summary report and a copy of 55 PA code 2600 is posted in a conspicuous and public place (see attached letter A)
Results of these audits will be reviewed monthly via QA process

Documentation of all audits shall be maintained for Department review. SMP 10/18/19

Administrator or designee will ensure current license, and a copy of current license inspection summary is always posted in a conspicuous place in the home .

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

Date 8/15/19

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

The above plan of correction is approved as of 09-11-19 (Date)

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

Plan of correction implementation status as of 09-11-19 (Date)

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

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

Personal care and assisted living homes must post the required influenza information in a public place in the home year-round. According to the Influenza Awareness Act (HB 1785). On 07-01-19, the home did not have an influenza poster anywhere.

Plan of Correction (POC)

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

On 7/9/19 at time of survey,ED posted Influenza Information Poster in front entry foyer
ED trained regarding posting Influenza Poster in a public place. Administrator credentials posted in survey binder.
ED and/or designee will complete weekly audit for 4 weeks, then monthly audit for 2 months to ensure Influenza information poster is posted in a public place (see attached letter A)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure influenza poster is always posted in a conspicuous place in the home .

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director 8/15/19
Printed Name and Title Date

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

The above plan of correction is approved as of 09-11-19 (Date)

Plan of correction implementation status as of 09-11-19 (Date)

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

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

41c - Rights Poster

Regulations

2600.
41.c. The Department's poster of the list of resident's rights shall be posted in a conspicuous and public place in the home.

Description of Violation

On 07/09/2019, the Department's resident's rights poster was not posted in a conspicuous and public place in 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.)

On 7/9/19 ED posted list of Residents Rights Poster in front lobby.
ED trained regarding posting list of Residents Rights in a conspicuous and public place. Administrator credentials posted in survey binder.
ED and/or designee will complete weekly audit for 4 weeks, then monthly audit for 2 months to ensure list of Residents Rights poster is posted in a conspicuous and public place (see attached letter A)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure resident rights poster is always posted in a conspicuous place in the home.

SP 09-11-19

Legal Entity Representative

Earl Stingel — Signature

Earl Stingel — Printed Name and Title

8/15/19 — Date

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

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

Plan of correction implementation status as of 09-11-19 (Date)

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

44g - Telephone Number

Regulations

2600.
44.g. The telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Pennsylvania Protection & Advocacy, Inc., the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline shall be posted in large print in a conspicuous and public place in the home.

Description of Violation

On 07-01-19, the telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline was not posted in a conspicuous and public place in 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.)

On 7/9/19 ED posted the telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline in the front lobby.
ED trained regarding posting the telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline in a conspicuous and public place. Administrator credentials posted in survey binder.
ED and/or designee will complete weekly audit for 4 weeks, then monthly audit for 2 months to ensure the telephone number of the Department's personal care home regional office, the local ombudsman or protective services unit in the area agency on aging, Disability Rights Pennsylvania (DRP) the local law enforcement agency, the Commonwealth Information Center and the personal care home complaint hotline is posted in a conspicuous and public place (see attached letter A)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure all telephone numbers specified in 2600.44g are always posted in a conspicuous place in the home.

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel 8/15/19
Printed Name and Title — Date

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65a - FS Orientation 1st Day

Regulations

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was 05/16/2019, did not receive an orientation in general fire safety and emergency preparedness until 06/20/2019.

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.)

Staff Person A was trained in general fire safety and emergency preparedness on 06/20/19 by National Care Specialist
On 06/14/19 National Care Specialist audited employee files to ensure employees received general fire safety and emergency preparedness training prior to or on their first work day. As of 06/20/2019 employees have received training on general fire safety and emergency preparedness.
ED trained regarding ensuring employees received general fire safety and emergency preparedness training prior to or on their first work day. Administrator credentials posted in survey binder.
New Hire Process will include Staff Training for Personal Care Homes checklist, which includes general fire safety and emergency preparedness training prior to or on the first work day (attachment B1 and B2)
ED and or/designee will audit new employee files weekly audit for 4 weeks, then monthly audit for 2 months to ensure employees received general fire safety and emergency preparedness training prior to or on their first work day (attachment C)
Results of these audits will be reviewed monthly via QA process

Please see attached....... Repeat violation 08/13/18

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

8/15/19
Date

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2600.65a

Within 30 days of receipt of the accepted plan of correction - The administrator or designee will review all training records for staff to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in all aspects with regulation 2600.65(a). Documentation of the training shall be kept in the employee's record and made available for Department review. Audits and monitoring will be made available for Department review.

SP 09-11-19

65b - Rights/Abuse 40 Hours

Regulations

2600.

65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff person A, whose first day of work was 05/16/19, did not receive an orientation in resident rights, emergency medical plan, mandatory reporting of abuse and neglect, and reporting of reportable incidents and conditions within 40 scheduled working hours.

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.)

Staff Person A was trained on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions on 06/20/19 by National Care Specialist On 06/14/19 the National Care Specialist audited employee files to ensure employees received training on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions within 40 scheduled working hours. As of 06/20/2019 employees have received training on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions

ED trained regarding ensuring employees received training on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions within 40 scheduled working hours. New Hire Process will include Staff Training for Personal Care Homes checklist, which includes Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions within 40 scheduled working hours (attachment B1 and B2). Administrator credentials posted in survey binder.
ED and or/designee will audit new employee files weekly audit for 4 weeks, then monthly audit for 2 months to ensure employees received Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions within 40 scheduled working hours (attachment C)
Results of these audits will be reviewed monthly via QA process

Please see attached.......

Legal Entity Representative

Earl Stingel

Signature

Earl Stingel Executive Director 8/15/19

Printed Name and Title Date

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- [ ] Not Implemented

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

2600.65b

Within 30 days of receipt of the accepted plan of correction - The administrator or designee will review all training records for staff to ensure all direct care staff persons including ancillary staff persons, substitute personnel and volunteers have completed an orientation in all aspects with regulation 2600.66(b). Documentation of the training shall be kept in the employee's record and made available for Department review. Audits and monitoring will be made available for Department review. All new employees will receive training within 40 hours.

SP 09-11-19

65e - 12 Hours Annual Training

Regulations

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person B received only 10.75 hours of annual training in training year 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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Direct Care Staff person is scheduled to received 12 hours of annual training related to their job dutiesin year 2019
ED and/or designee trackingcurrent direct care employee files to ensure they are scheduled to receive 12 hours of annual training related to their job duties in 2019. Adult Residential Licensing-Personal Care Homes Staff Training Plan- 55 Pa. code 2600.66 will be used (see attachment D)
ED trained regarding ensuring direct care employees received at least 12 hours of annual training relating to the job duties. ED credentials in state survey binder.
ED and/or designee will audit 5 direct care employee files weekly for 4 weeks then monthly for 2 months to ensure compliance with scheduled trainings related to their job duties (see attachment E 2
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure all direct care staff persons receive 12 hours annual training related to their job duties. Within 30 days receipt of accepted plan of correction all direct care staff persons files will be audited to record annual training received in 2019. All direct care staff will receive at least 12 hours training in 2019. Training schedule will be kept in each staff members file for review. Audits and monitoring conducted by home will be made available for Department review.

SP 09-11-19

Legal Entity Representative

Earl Stingel | Earl Stingel Executive Director | 8/15/19
Signature | Printed Name and Title | Date

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65f - Training Topics

Regulations

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.

Description of Violation

Direct care staff person B did not receive training in topics

1.Medication self-administration training.

2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

3. Care for residents with dementia and cognitive impairments.

4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.

5. Personal care service needs of the resident.

6. Safe management techniques.

Repeat Violation - 8/13/18

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.)

Legal Entity Representative

Earl Stingel

Signature

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65.f

Direct Care Staff Person B will receive training by 8/30/19 related to:

1) Medication self-administration

2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan

3) Care for residents with dementia and cognitive impairments

4) Infection Control and general principles of cleanliness and hygiene and areas associated wit immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration

5) Personal Care services needs of the residents

6) Safe Management techniques

ED and/or designee trackin current direct care employee files to ensure they are scheduled to receive training on each topic covered in regulation 2600.65.f in 2019. Adult Residential Licensing-Personal Care Homes Staff Training Plan- 55 Pa. code 2600.66 will be used (see attachment D)

ED trained regarding ensuring direct care employees received annual training on topics:

1) Medication self-administration

2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan

3) Care for residents with dementia and cognitive impairments

4) Infection Control and general principles of cleanliness and hygiene and areas associated wit immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration

5) Personal Care services needs of the residents

6) Safe Management techniques

ED and/or designee will audit 5 direct care employee files weekly for 4 weeks then monthly for 2 months to ensure compliance with scheduled annual trainings covering each topic in regulation 2600.65.f S

Results of these audits will be reviewed monthly via QA process

Earl Stingel Earl Stingel Executive Director 8/15/19

Administrator or designee will ensure direct care staff person B is trained on all aspects of regulation 2600.65f immediately. Within 30 days receipt of POC all direct care staff files will be audited to ensure all staff have been trained in regulation 2600.65f. All direct care staff persons will be trained annually on regulation. Verification of training will be kept in staff members files and made available for Department review. Inservice, monitoring, and audits will be documented by home and made available for Department review. SP 09-11-19

65g - Annual Training Content

Regulations

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
5. Falls and accident prevention.

Description of Violation

Staff person B did not receive training in falls and accident prevention during training year 2018.
Repeat Violation - 8/13/18

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.)

Staff person B will receive training on falls and accident prevention by 8/30/2019
ED and/or designee audited current employee files on 08/09/2019 to ensure they received training on falls and accident prevention. Employees identified as not receiving falls and accident prevention training will training by 08/30/2019 Adult Residential Licensing-Personal Care Homes Staff Training Plan- 55 Pa. code 2600.65 will be used (see attachment D)
ED trained regarding ensuring employees received falls and accident prevention training annually. ED credentials in survey binder.
ED and/or designee will audit 5 employee files weekly for 4 weeks then monthly for 2 months to ensure compliance with scheduled annual trainings on falls and accident prevention (see attachment E2)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure direct care staff person B is trained on all aspects of regulation 2600.65g immediately. Within 30 days receipt of POC all direct care staff files will be audited to ensure everyone has been trained in regulation 2600.65g. All direct care staff persons will be trained annually on regulation. Verification of training will be kept in staff members files and made available for Department review. Inservice, monitoring, and audits will be documented by home and made available for Department review.

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director 8/15/19
Printed Name and Title / Date

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85d - Trash Receptacles

Regulations

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 07/01/2019, there was an uncovered trash can in the home's F hall common bathroom.

Plan of Correction (POC)

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

On 7/1/19 ED replaced trash can lid in F hall common bathroom
On 7/1/19 ED and /or designee completed community round in kitchen and bathrooms to ensure trash receptacles were covered, with no other trash receptacles noted to be affected
Maintenance Tech received re-education regarding ensuring trash receptacles in kitchen and bathrooms were to be kept covered on 8/8/19 by Earl Stingel ED (see attachment F1, F2, F3)
Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure trash receptacles in kitchen and bathrooms were to be kept covered (see attachment G)
Results of these audits will be reviewed monthly via QA process

Audits to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel — Signature

Earl Stingel Executive Director — Printed Name and Title

8/15/19 — Date

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Plan of correction implementation status as of 09-01-19 (Date)

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

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 07/01/2019, the home's shower room in hallway A and shower room in hallway D, had stains on the ceiling.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Maintenance Tech and/or designee painted ceilings in shower room A and shower room D on August 13, 2019.
ED completed community round on 08/09/2019 to ensure ceilings in other areas were free from stains, no other ceilings noted to be affected,
Maintenance Tech received re-education regarding regulation 2600 88.a including ceilings must be clean in good repair and free from hazards by the ED on 8/8/19 (see attachment F1, F2, F3)
Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure ceilings are clean in good repair and free from hazards (see attachment G)
Results of these audits will be reviewed monthly via QA process.

Audits to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

8/15/19
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96a - First Aid Kit

Regulations

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the home does not include the following items:

eye coverings

thermometer

breathing shield

tweezers

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.)

First Aid Kit that included nonporous gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers was placed in the front office reception area by the ED on 07/20/2019
ED trained on requirements for first aid kit in home to include nonporous gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers on 08/09/2019 by DCSS. ED credentials in survey binder.
ED and/or designee will audit first aid kit weekly for 4 weeks then monthly for 2 months to ensure kit includes nonporous gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers (see attachment H)
Results of these audits will be reviewed monthly via QA process

Audits to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

8/15/19
Date

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102i - Soap Dispenser

Regulations

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There were unlabeled used bars of soap in the home's B hallway and E hallway shower stalls.

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.)

Unlabeled bars of soap were removed B hallway and E hallway shower stalls by ED on 7/1/19 and replaced with personal body wash.
ED ordered body wash dispensers on 08/09/19 with estimated arrival on 08/16/2019 Dispensers will be mounted to shower walls upon arrival
ED completed community round on 08/09/2019 on shared bathrooms, including shower stalls to ensure no unlabeled bars of soap was present, no other unlabeled bars of soap noted
Housekeeping and Care Staff re-educated on regulations 2600 102.i including the use of soap dispensers and not using unlabeled bar soap in shared bathrooms by the ED on 8/8/19 (see attachment I1 and I2)
Housekeeping staff and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure no unlabeled bars of soap are being used in shared bathrooms including shower stalls (see attachment J)
Results of these audits will be reviewed monthly via QA process

Audits and inservices to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director 8/15/19
Printed Name and Title Date

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102k - No Common Towel

Regulations

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

On 07/01/2019, there was an unlabeled used wash towel hanging in the shower stall in the home's common shower room in hallway D.

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.)

Used wash towel was removed from shower stall in common shower room in hallway D by ED on 7/1/19
ED completed community round on 08/09/2019 on shared bathrooms, including shower stalls to ensure unlabeled used towels were present. No other unlabeled use towels noted.
ED and/or designee placed laundry hampers in each shower room for immediate removal of used washcloths and towels on 08/16/2019
Housekeeping and care staff re-educated on regulations 2600 102.k including the use of common towels being prohibited by ED on 8/8/19 (see attachment I1 and I2)
Housekeeping staff and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure no unlabeled towels are being used in shared bathrooms or shower stalls (see attachment J)
Results of these audits will be reviewed monthly via QA process

Audits and inservices to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel	Earl Stingel, Executive Director	8/15/19
Signature	Printed Name and Title	Date

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107d - Procedure Emergency Management Agency Submission

Regulations

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures have not been submitted to local emergency agency.

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.)

Communities written emergency procedures were sent to local emergency agency by the ED on 8/9/19
ED trained on regulations requiring community to submit their written emergency procedure to local emergency agency
Community staff will be educated on Emergency Procedures by the ED, education to be completed by 8/20/19
The written emergency procedure will be reviewed, updated as needed, and submitted to the local emergency agency by the ED annually

Administrator or designee will ensure emergency procedures are submitted to the local emergency management agency annually. Staff in-service and verification of submission will be documented and made available for Department review.

SP 09-11-19

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Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

8/15/19
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162c - Menus Posted

Regulations

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 07/01/2019, there were no weekly menus posted in a conspicuous and public place in 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.)

Weekly menu was posted by the chef on 7/8/19 in the dining room.
Chef and dining staff re-educated on requirement, including to have weekly menus posted in a conspicuous and public place in the home on 8/8/19 by the ED (see attachment K1 an dK2)
ED and/or designee will complete an audit weekly for 4 weeks then monthly for 2 months to ensure menus are posted in a conspicuous and public area (see attachment A)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure menus are always posted in a conspicuous place in the home . Audits will be kept for Department review. SP 09-12-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director
Printed Name and Title

8/15/19
Date

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- ☐ Fully Implemented
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- ☐ Not Implemented

185a - Implement Storage Procedures

Regulations

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 has an order for blood glucose level checks twice a day. On 07/06/2019, her glucometer registered 4 readings of 230, 111, 175, and 58, but her medication administration record (MAR) lists only one reading of 211.

On 07/08/2019, resident #1's reading on the glucometer was 195 while the MAR read 196.

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.)

Current residents who receive glucometer checks were audited to ensure MD orders are followed related to glucometer checks and that glucometer reading are documented correctly by the CSM and/or designee on 07/30/2019with results of these findings presented to residents MD as needed
LPN who performed glucometer checks on Resident #1 on 7/6/19 an d7/8/19 no longer works in community as of 7/30/2019
Nurses and Med Techs were re-educated on regulations 2600.185.a including following MD orders and documenting findings correctly by the ED on 8/8/19 (see attachment L1, L2, L3, and L4)
Received new order 7/11/19 for PRN Accucheck for signs and symptoms of hypo/hyperglycemia.
CSM and/or designee will perform audits on current residents receiving glucometer checks weekly for 4 weeks then monthly for 2 months to ensure MD orders are followed and glucometer readings are documented correctly (see attachment M)
Results of these audits will be reviewed monthly via QA process

Home sent in verification nurses and MedTech's were trained on glucometers and documentation. Glucometer checks and audits will be maintained by home and made available for Department review.

SP 09-12-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director 8/15/19
Printed Name and Title Date

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The above plan of correction is approved as of 09-12-19 (Date)

Plan of correction implementation status as of 09-12-19 (Date)

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

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

187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
 12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #2 is prescribed Senna 8.6 mg. However, her medication administration record (MAR) does not indicate its diagnosis.

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 #2 MAR was corrected to include diagnosis for Senna 8.6 mg by CSM on 7/1/19
CSM and/or designee reviewed current MAR to ensure medications had a diagnosis or purpose listed on 07/30/2019 with corrections made as needed
Nurses and Med Techs re-educated on regulations 2600.187.a.12 including that all medications must include a diagnosis or purpose for use listed on the MAR by the ED on 8/8/19 (see attachment L1, L2, L3, and L4)
CSM and/or designee will perform audits on 5 residents MAR's weekly for 4 weeks then monthly for 2 months to ensure medications have a listed diagnosis or purpose of use (see attachment N1 and N2)
Results of these audits will be reviewed monthly via QA process

Immediately: A staff person qualified to administer medications will conduct an initial and monthly review of all current resident MARs and prescriber's orders to insure all prescribed medications are documented on the resident's MAR's in accordance with regulation 2600.187(a). Home did provide verification med techs and nurses were trained on medication administration records. Audits to be maintained for Department review.

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director 8/15/19
Printed Name and Title Date

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187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed weekly blood pressure checks on Mondays. However, on 07/01/19 and 07/08/19, her blood pressure was not checked. There was no documentation of blood pressure readings.

Repeat Violation - 8/13/18

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 #2 blood pressure was checked by the care provider and recorded in the MAR by the CSM on 07/15/2019. Resident #2 MD notified and discontinued routine blood pressure monitoring on 07/30/2019.
CSM and/or designee completed audit on 07/30/2019 of current residents with orders for blood pressure checks to ensure blood pressure documented correctly, findings reviewed with resident's MD as needed
Nurses and Med Techs re-educated on regulations 2600.187.d including following prescribers' directions by the ED on 8/8/19 (see attachment L1, L2, L3, and L4)
CSM and/or designee will perform audits on 5 residents MAR's weekly for 4 weeks then monthly for 2 months to ensure prescribers directions are followed (see attachment N1, N2)
Results of these audits will be reviewed monthly via QA process

Within 30 days receipt of this POC, the administrator or designee qualified to administer medications shall complete an initial audit of all resident MARs to ensure all prescribed medications are available, administered as prescribed, and the administration of the medication is documented on the MARs in accordance with regulation 2600.187(b). All training and audit documentation to be maintained by home for Department review.

SP 09-11-19

Repeat violation 08/13/18

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director
Printed Name and Title

8/15/19
Date

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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 Secure Dementia Care Unit (SDCU) on 01/09/2019. However, the resident's medical evaluation was completed on 10/16/2018.

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.)

CSM and/or designee completed audit of current residents to ensure compliance with regulation 2600.231.b with results of these findings reviewed with residents MD as needed on 07/30/2019
CSM re-educated on regulation 2600.231.b in which a resident shall have a medical evaluation by a physician, physicians assistant or certified registered nurse practitioner, documented on a form provided by the Department within 60 days prior to admission by the DCSS on 8/8/19 (see attachment O1, O2, and O3)
ED and/or designee will audit new admission medical records weekly for 4 weeks then monthly for 2 months to ensure a resident has a medical evaluation by a physician, physicians assistant or certified registered nurse practitioner, documented on a form provided by the Department within 60 days prior to admission (see attachment P)
Results of these audits will be reviewed monthly via QA process

Audits and inservices to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel, Executive Director 8/15/19
Printed Name and Title Date

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231c - Preadmission Screening

Regulations

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #3 was admitted to the Secure Dementia Unit (SDCU) on 01/09/2019. However, the resident's written cognitive prescreening was completed on 01/04/2019.

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 has suffered no negative outcome related to these findings
CSM re-educated on regulation 2600.231.c in which a written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit by the DCSS on 8/8/19 (see attachment O1, O2, and O3).
ED and/or designee will audit new admissions to secured dementia units medical records weekly for 4 weeks then monthly for 3 months to ensure a written cognitive preadmission screening is completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form and completed for each resident within 72 hours prior to admission to the secured dementia care unit (see attachment P).
Results of these audits will be reviewed monthly via QA process

Audits and inservices to be made available for Department review. SP 09-11-19

Legal Entity Representative

Earl Stingel — Signature

Earl Stingel Executive Director — Printed Name and Title

8/15/19 — Date

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234a - Admission Support Plan

Regulations

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 05/03/2019. However, the resident's initial support plan was completed on 05/15/2019.

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.)

234.a
Resident #4 no longer resides in the community
CSM and/or designee completed audit of current residents residing in the secured dementia care unit to ensure support plans completed by 05/30/3019 with no other residents noted to be affected.
Audit/Tickler file completed and maintained for current residents by the CSM to track DME/RASP as of 05/30/2019 and ongoing(see attachment Q1 and Q2)
CSM re-educated on admission support plan requirements by the DCSS on 5/13/19 (see attachment R1-R6)
ED and/or designee will audit new admissions including admissions to secured dementia unit medical records weekly for 4 weeks then monthly for 2 months to ensure a support plan is developed and implemented and documented within 72 hours of the admission or within 72 hours prior to admission to the secured dementia care unit (see attachment P)
Results of these audits will be reviewed monthly via QA process

Audits and inservices to be made available for Department review.

SP 09-11-19

Legal Entity Representative

Earl Stingel — Signature
Earl Stingel, Executive Director — Printed Name and Title
8/15/19 — Date

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- ☐ Not Implemented

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234e - Involvement/Participation

Regulations

2600.
234.e. The resident or the resident's designated person shall be involved in the development and the revisions of the support plan.

Description of Violation

The support plans for resident #3 dated 05/20/2019, resident #4 dated 05/15/2019, and resident #5 dated 05/06/2019, had no indication that the residents or the resident's designated person was involved in the development of the support plan.

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 support plan reviewed with designated person via phone on 7/15/19 by CSM
Resident #4 no longer resides in the community
Resident #5 support plan reviewed with designated person via phone on 7/15/19 by CSM
CSM and/or designee completed audit on current resident medical record to ensure residents designated person was involved in the development of the support plans on 07/15/2019 with findings reviewed with the designated person as needed
CSM re-educated on Involvement/Participation by residents designated person in the development of the residents support plan by the DCSS on 5/13/19 (see attachment O1, O2, O3 and R1-R6)
ED and/or designee will audit 5 residents medical records weekly and all new admissions for 4 weeks then monthly for 2 months to ensure a support plan is developed with involvement and participation from residents designated person (see attachment P)
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure all individuals specified in 2600.234e are involved in the development and revisions of support plans. Audits and staff in-services to be made available for Department review.

SP 09-11-19

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236 - Staff Training

Regulations

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person B, who works in the Secure Dementia Care Unit (SDCU), had only 5 hours of training in dementia care during 2018 training year. Repeat Violation - 8/13/18

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.)

Direct Care Staff person B had a total of 7.5 hours of Dementia training in 2018. 3 hours were via Relias online training and 4.5 hours were in person CARES training for a total of 7.5 hours (see attachment S1-S11)
Park Creek Place Memory Care request to have violation 2600.236 withdrawn
ED and/or designee completed audit on 08/09/2019 of current direct care employees working on secured dementia unit to ensure 6 hours of dementia training is completed in addition to the 12 hours of annual training
ED trained on regulation 2600.236 which includes that each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in 2600.65. Credentials in survey binder
ED and/or designee will audit 5 direct care employee files weekly for 4 weeks then monthly for 2 months to ensure compliance with scheduled dementia care trainings in additional to annual trainings (see attachment E2
Results of these audits will be reviewed monthly via QA process

Administrator or designee will ensure all staff persons working in the memory care unit have 6 hours annual training related to dementia care services in addition to the 12 hours annual training. Audits and staff in-services to be made available for Department review along with staff training records.

SP 09-11-19

Legal Entity Representative

Earl Stingel
Signature

Earl Stingel Executive Director
Printed Name and Title

8/15/19
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