



Sent via e-mail rgreer@benchmarkquality.com
Sent via e-mail scoront@benchmarkquality.com
July 27, 2020

Mr. Robert Greer
Executive Director
ARHC WHWCHPA01 TRS, LLC
1361 East Boot Road
West Chester, Pennsylvania19380

RE: Wellington Court at Hershey's Mill
License #: 141360

Dear Mr. Greer:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on December 9, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Shawn Parker

Shawn Parker
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: WELLINGTON COURT AT HERSHEY'S MILL
Address: 1361 EAST BOOT ROAD,, WEST CHESTER, PA 19380
County: CHESTER Region: SOUTHEAST

License Number: 14136

Administrator

Name: Sandra Coront Phone: 4846200877 Email: scoront@benchmarkquality.com

Legal Entity

Name: ARHC WHWCHPA01 TRS LLC
Address: 1361 EAST BOOT ROAD, EXECUTIVE DIRECTOR, WEST CHESTER, PA, 19380

Certificate(s) of Occupancy

Type: I-2 Date: 02/10/2015 Issued By: East Goshen Township

Staffing Hours

Resident Support Staff: 105 Total Daily Staff: 170 Waking Staff: 128

Inspection

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

Inspection Dates and Department Representative

12/09/2019 - On-Site: Christina Eberhart, Sandra Wooters, Charlotte Wiley

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 74 Residents Served: 65

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 6

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 65
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
Have Mobility Need: 0 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 12/9/19 the home's most recent license inspection summary was not posted in a conspicuous and public place in the home.

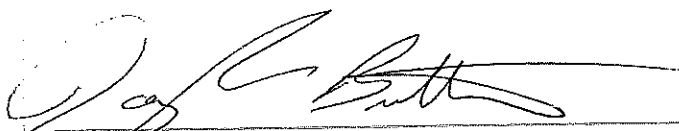
Plan of Correction (POC)

(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.)

1. No resident was cited by this practice; the Personal Care Administrator (PCA) put the last three years of the surveys in the binder and placed it in a conspicuous and public place near the receptionist desk when the surveyor identified the issue.
2. Residents were not affected by this practice.
3. It was determined that the Personal Care Administrator had not ensured that all three years of past surveys were in the survey binder for public view. The PCA/designee audited and corrected the survey binder immediately. Policy and procedures were reviewed, and no revisions were necessary to achieve regulatory compliance.
4. The PCA/designee will audit the public survey binder annually to ensure compliance. Variances will immediately be corrected. Audit findings will be reported to the QAPI committee during the monthly meetings. The QAPI committee will review outcomes and give recommendations as appropriate for compliance. Result thresholds are established at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Administrator or designee will ensure the current license, the current license inspection summary, and the 2600 regulation book is always posted in a conspicuous and public place in the home in accordance with regulation 2600.3c.

SP 07-22-2020
Legal Entity Representative


Signature

DOUGLAS C BUTNER Ex Dir. 1/2/20
Printed Name and Title Date

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The above plan of correction is approved as of 07-22-2020
(Date)

Plan of correction implementation status as of 07-22-2020
(Date)

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

Implemented
 Not Implemented

26b - Quality Management Plan Content

Regulations

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

- 1. The reportable incident and condition reporting procedures.
- 2. Complaint procedures.
- 3. Staff person training.

Description of Violation

The home's quality management review dated 2/1/19 did not address staff training.

Plan of Correction (POC)

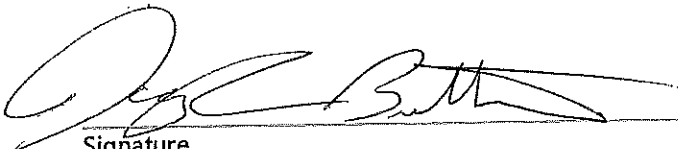
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- 1. No resident was identified by this practice. Revisions were made to the QAPI management committee policy. The QA policy was reviewed and adjusted to include staff training.
- 2. The residents have the potential to be affected by this practice.
- 3. It was determined that the policy for QA did not include staff training. The PCA/designee reviewed the policy and made corrections to achieve compliance.
- 4. The PCA/designee will review the QA policy annually to ensure regulatory compliance. Variances will be immediately corrected. Findings will be reported during the annual QA meeting. The QA committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Administrator or designee will ensure the homes quality management plan addresses all aspects of regulation 2600.26b

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Legal Entity Representative



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28e - Death of a Resident

Regulations

2600.

28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #1 passed away on [redacted] 19. Resident #1's personal belongings were removed from her room on [redacted] 19; however, a refund in the amount of \$4,443.37 was not issued to her estate until 8/22/19.

Plan of Correction (POC)

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

1. Resident #1 no longer resides in the community. The refund amount of \$4443.37 was issued to resident #1's estate on 8/22/2019.
2. Residents have a potential to be affected by this practice.
3. It was determined that accounting did not issue the refund within the 30 day time limit. The community controller has reported this practice of the necessity to issue refunds within 30 days of a resident removing personal belongings from a rented apartment. The community controller/designee will audit current refunds to ensure regulatory compliance. Policies and procedures were reviewed and no changes were necessary to achieve regulatory compliance.
4. The community controller/designee will audit residents' refunds weekly times 4 then monthly. Variances will immediately be corrected. The audit findings will be reported during the QAPI committee meeting. The QAPI committee will review outcomes then make recommendations as appropriate for improvement. Result thresholds are set at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Legal Entity Representative


Signature

DOUGLAS C BUTNER Exp. Dir. 1/2/20
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51 - Criminal Background Check

Regulations

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member B was hired on 8/23/19. There was no criminal background check for the staff member on file.

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.)

1. No resident was identified by this cited practice. The Food and Beverage Director was notified that staff member B had no documentation related to their pre-hire criminal background check. The staff member was immediately removed from the schedule.
2. Residents had the potential to be affected by this practice.
3. It was determined that the F&B Director had not ensured all staff members had followed the policy relating to pre-hire criminal background check. The F&B Director was in-serviced related to the employment pre-hire policy/regulation. The F&B director audited all current employees to ensure that pre-hire criminal background checks have been completed. Any variance will be corrected as appropriate. Policies and procedures were reviewed and no changes were necessary to achieve regulatory compliance.
4. The F&B Director/designee will audit pre-hire paperwork for new employees prior to scheduling. All variances will be immediately corrected. Audit outcome will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Administrator or designee will ensure all criminal history background checks are completed timely and in accordance with regulation 2600.51.

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Signature

DOUGLAS C BUTCHER, Ex Dir 1/26/20

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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).

Description of Violation

Staff person B was hired on 8/23/19. However, this staff person did not complete training in the following topics within his first 40 hours of employment:

Resident Rights

Emergency Medical Plan

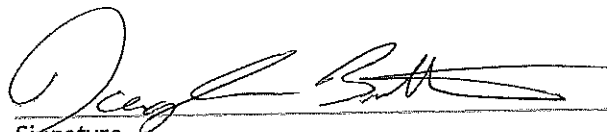
Older Adult Protective Services Act

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.)

- 1. No resident was indentified by this practice. The Personal Care Administrator in-serviced all present staff on the day the surveyor identified the issue related to resident rights.
- 2. The residents had the potential to be affected by this practice.
- 3. It was determined that the residents' rights, emergency medical plans, and older adult protective services act were not incorporated into the Benchmark 3 day orientation process. The HR director/designee will audit current staff files to ensure compliance related to orientation for resident rights, emergency medical plan, and older adult protective services act. The HR director/designee will in-service all existing staff that are found non-compliant. The HR director/designee will incorporate the training for residents rights, emergency medical plans, and the older adult protective services act into the three day orientation process. Policies and procedures were reviewed and no revisions were necessary.
- 4. The HR director/designee will audit new staff monthly to monitor for compliance. Variances will be corrected immediately. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Legal Entity Representative



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DOUGLAS C BUTTNER, Sr. Dir 11/2/20

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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:

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

Description of Violation

Direct care staff persons D and E did not receive training in instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan for 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 occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- 1. No resident was indentified by this practice. Staff persons D and E were in-serviced to meet the needs of the resident.
- 2. Residents had the potential to be affected by this practice.
- 3. It was determined that the training process for staff D and E did not incorporate the instructions to meeting the needs of the residents as it is related to the pre-admission screening forms. Policies and procedures were reviewed and no changes were necessary to achieve regulatory compliance.
- 4. The HR director/designee will audit existing PC staff for training compliance. Variances will be immediately corrected. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Admin or designee will ensure direct care staff training plans include all the training topics specified in regulation 2600.65f.

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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:

- 3. Resident rights.
- 5. Falls and accident prevention.

Description of Violation

Staff persons D and E, did not receive training in Resident Rights and Falls and Accident Prevention during 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 occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- 1. No resident was identified by this practice. The Personal Care Administrator in-serviced all present staff on the day the surveyor identified the issue related to resident rights. Staff members D and E were in-serviced during the week of the cited practice for both resident rights and fall and accident prevention.
- 2. Residents had the potential to be affected by this practice.
- 3. It was determined that resident rights and falls and accident prevention were not completed with all staff annually. The PCA/designee will audit the current PC staff files to ensure compliance. The PCA/designee will in-service all PC staff related to resident rights and falls and accident prevention. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
- 4. The PCA/designee will audit staff files monthly to monitor for compliance. Variances will immediately be corrected. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review the outcomes and give recommendations as appropriate for improvement. Result thresholds are set at 100%. The frequency of audits will be adjusted by the QAPI committee according to outcomes.

Admin or designee will ensure direct care staff, ancillary staff persons, substitute personal, and regularly scheduled volunteers are trained in all aspects specified in regulation 2600.65g.

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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 12/9/19 at 10 :45 am, there was an uncovered, unattended trash can in the kitchen. Staff were washing dishes at the time, the trash can was not in use.

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.)

1. No resident was indentified by this practice.
2. Residents had the potential to be affected by this practice.
3. It was determined that the Food and Beverage Director had not ensured the staff was following policy related to covering trash containers. The F&B Director/designee has in-serviced the staff on the procedures related to covering the trash containers per policy. The F&B Director/designee will monitor the trash containers daily for compliance. Policies and procdures were reviewed and no changes were necessary to achieve regulatory compliance.
4. The F&B Director/designee will audit trash containers weekly to monitor for compliance and replacement needs. Variances will be immediately corrected. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are set at 100%. The frequency of the audits will be adjusted according to outcomes.

Legal Entity Representative


Signature

DOUGLAS C BUTNER, Ex Dir. 11/2/20
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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 12/09/19 at 2:07 pm Resident #2 had a mattress covered in plastic on the floor in their bedroom posing a tripping hazard.

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.)

1. Resident #2 resides in the community. Mattress was removed to a safe area. PC Administrator called family member to put new mattress in place and remove old mattress. Family member agreed to do so that day.
2. Residents had the potential to be affected by this practice.
3. It was determined that a resident family member brought in a new mattress, placing it in the room the night before the survey and did not notify staff. PC Administrator to notify current residents and their families to inform staff when bringing in or removing furnishings. The PCA/designee will in-service staff to report to their supervisor any unsafe conditions upon discovery. Policies and procedures were reviewed and no changes were necessary to achieve regulatory compliance.
4. The PCA/designee will audit 10% of residents' rooms weekly times 4 then monthly thereafter. Variances will be immediately corrected. Audit findings will be reported during the monthly QAPI meetings. The QAPI committee will review outcomes and give recommendations as appropriate for improvements. Result thresholds are established at 100%. Frequency of audits will be adjusted according to outcomes by the QAPI committee.

Legal Entity Representative



 Signature

DOUGLAS C BUTTNER, EC Dir. 11/2/20

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101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

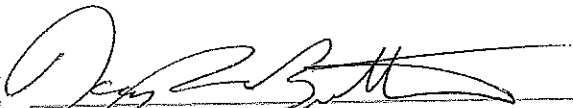
Resident #3 does not have access to a source of light that can be turned on/off at bedside.

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.)

1. Resident #3 resides in the community. The PCA reached out to family to provide a lamp for the resident's bedside. Resident stated that she is happy with her furnishings.
2. Residents had the potential to be affected by this practice.
3. It was determined that the resident's family did not provide a bedside lamp for the resident in accordance with admissions policy. The PCA/designee will have chairman of resident council address this issue with residents during their monthly meeting. Policies and procedures were reviewed and no changes were necessary to achieve regulatory compliance.
4. The PCA/designee will audit 10% of the current resident rooms monthly for appropriate lighting. Variances will be immediately addressed with family for corrections. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are set at 100%. The frequency of the audits will be adjusted according to outcomes.

Legal Entity Representative



 Signature

DOUGLAS C BUTTNER 1/2/20
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103e - Left Overs

Regulations

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 12/09/19 at 11:15 am the snack refrigerator on the 3rd floor had a covered bowl of ice cream with no label.

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.)

1. No resident was indented by this practice. The items were removed from the resident nourishment room refrigerator and disposed of.
2. Residents had the potential to be affected by this practice.
3. It was determined that the staff had not dated and labled items in the resident's refrigerator. The Food and Beverage Director/designee will in-service all PC staff on policies related to food storage. Policies and procedures were reviewed and revisions were not necessary to achieve regulatory compliance.
4. The Food and Beverage Director/ designee will audit the resident nourishment room refrigerators related to food storage weekly times eight weeks then monthly thereafter. Variances will be corrected immediately. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and make recommendations for improvement. Result thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.

Admin or designee will ensure all leftovers are labeled and dated, and handled in a manner specified in regulation 2600.103e.

SP 07-22-2020

Legal Entity Representative


 Signature

DOUGLAS C BOTWINER, EX DIR 11/2/20
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103i - Outdated Food

Regulations

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

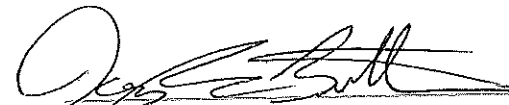
On 12/09/19 at 10:45 am a dented can of Bush's Baked Beans was found in the kitchen.

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.)

1. No resident was indentified by this practice. The dented can was removed when identified by surveyor.
2. Residents had the potential to be affected by this practice.
3. It was determined that the Food and Beverage Director/ designee did not remove the slightly dented can when received on delivery. The Food and Beverage Director/designee will in-service all food and beverage utility and cook staff on policy related to food storage. Policies and procedures were reviewed and revisions were not necessary to achieve regulatory compliance.
4. The F&B director/designee will audit food storage areas for regulatory compliance weekly times eight weeks then monthly thereafter. Variances will be corrected immediately. Audit findings will be reported during the QAPI monthly meeting. The QAPI committee will review outcomes and make recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.

Legal Entity Representative


Signature

DOUGLAS C BUTTNER, Sr. Dir. 11/2/20
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103j - Utensils Cleaning

Regulations

2600.

103.j. Eating, drinking and cooking utensils shall be washed, rinsed and sanitized after each use by a method specified in 7 Pa. Code Chapter 46, Subchapter D (relating to equipment, utensils and linen).

Description of Violation


On 12/09/19 at 10:45 there was a crockpot with dried food covering the outside of the pot. The crockpot was not in use.

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.)

1. No resident was indented by this practice. The crock pot was cleaned when identified by surveyor.
2. Residents had the potential to be affected by this practice.
3. It was determined that the utility staff did not clean crock pot after service ended. The Food and Beverage Director will in-service utility staff member on policies related to cleaning crock pot after dining room service has ended. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
4. The F&B director/designee will audit related to the sanitation of the crock pots weekly times 8 weeks then monthly thereafter. Variances will be corrected immediately. Findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and make recomendations for improvement. Result thresholds are esablished at 100%. The frequency of audits will be adjusted according to outcomes.

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123a - Exit Doors

Regulations

2600.

123.a. Exit doors must be equipped so that they can be easily opened by residents from the inside without the use of a key or other manual device that can be removed, misplaced or lost.

Description of Violation

The exit door on the 3rd floor is locked is equipped with a keypad. There were no instructions to exit using the keypad. The home does not have SDCU. This is not a delayed egress.

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.)

1. No resident was identified by this process. The plant operations director put in place the instructions next to the door keypad immediately when identified.
2. Residents have the potential to be affected by this practice.
3. It was determined that the plant operations director had not ensured the proper signage for the keypad was in place. The plant operations director will in-service all maintenance staff to the regulations for door keypad instructions. The plant operations director/designee will audit all keypadded doors to ensure instructions are in place. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
4. The plant operations director/designee will audit all keypadded doors monthly to monitor for compliance. Variances will be corrected immediately. Audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of audits will be adjusted according to outcomes by the QAPI committee.

Admin or designee will ensure instructions and keypad code is posted so residents, staff, and visitors are able to utilize egress.

SP 07-22-2020

Legal Entity Representative


Signature

DOUGLAS C. BUTNER, Sr. Dir. 11/24/20
Printed Name and Title Date

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 (Date) Implemented (Date)

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141b1 - Annual Medical Evaluation

Regulations

2600.

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

Description of Violation

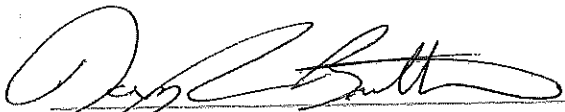
The Documented Medical Evaluation (DME) for Resident #4 was completed on the following dates: 2/28/18 and 3/25/19. More than 1 year and 15 days passed between the DME dates.

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.)

1. No resident was indentified by this practice. The PCA/ designee notified the attending physician about the importance of completing the DME in a timely manner.
2. The residents had the potential to be affected by this practice.
3. It was determined that the PCA had sent the DME to the attending physician 30 days' prior to due date. Telephone calls were made to attending physician after not receiving the DME 2 weeks before due date. DME still not completed in a timely manner. The PCA/ designee in-serviced all attending physicians with completing the DME according to policy and state regulations. The PCA/designee will audit the DME's monthly to ensure compliance. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
4. The PCA/designee will audit 10% of current resident charts for compliance of DME's monthly. Variances will be immediately corrected. Audit findings will be reported during the monthly QAPI meetings. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.

Legal Entity Representative


Signature

DOUGLAS C BUTNER, Ex Dir 1/2/20
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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

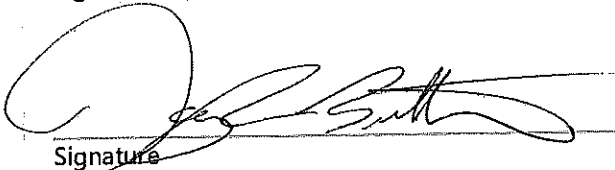
Resident #5's preadmission screening was completed on 7/17/19. Date of Admission was 8/27/19.
Resident #6's preadmission screening was completed on 1/8/19. Date of Admission was 3/27/19.

Plan of Correction (POC)

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

1. Residents #5 and #6 continue to reside in the community.
2. Residents have the potential to be affected by this practice.
3. It was determined by the PCA that the assessment for residents #5 and #6 were not completed within the 30-day timeframe prior to admission. Administrative LPN's will be in-serviced on timeliness of the assessment according to policy and state regulations. The PCA/designee will audit preadmission screening to ensure compliance. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
4. The PCA/designee will audit new charts on admission day to ensure compliance. Variances will be immediately corrected and audit findings will be reported during the monthly QAPI meeting. The QAPI committee will review outcomes and give recommendations as appropriate for improvement. Result thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.

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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

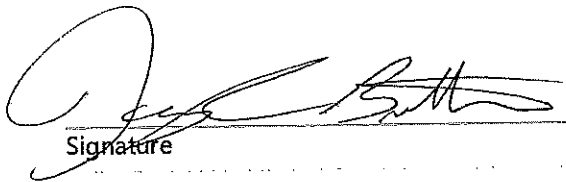
Resident #4 was admitted on 4/18/18; however, the resident's assessment was not completed until 5/4/18.

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.)

1. Resident #4 resides in the community.
2. Residents had the potential to be effected by this practice.
3. It was determined by the PCA that the 15 day assessment done on resident #4 was late. The PCA did not realize that is was past the 15 day completion date. Administrative LPN's will be in-serviced on the timeliness of the assessments according to policy and state regulations. The PCA/designee will audit 15-day assessment screenings to ensure compliance. Variances will be corrected immediately. Policies and procedures were reviewed and no revisions were necessary to achieve regulatory compliance.
4. The PCA/designee will audit new charts weekly x 4 weeks for admissions to ensure compliance. Variances will immediately be corrected. Audit findings will be reported during the monthly QAPI meeting. The QAPI will review outcomes and give recommendations as appropriate for improvement. Thresholds are established at 100%. The frequency of the audits will be adjusted according to outcomes.

Legal Entity Representative



Signature

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227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The Resident Assessment Support Plan (RASP) for Resident #7 dated 7/2/19, does not indicate how staff will meet her needs for her Wanderguard. The Wanderguard was attached to her walker and not on her person.


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.)

1. Resident #7 continues to reside in the community. Residents support plan (RASP) was completed according to state regulations. A copy of the Resident #7 RASP was faxed to the PA Department of Human Services on 12/9/2019, the day of survey. The RASP was found in the resident's existing chart by the PCA. See attached care plan.

Admin or designee RASP are completed and updated in accordance with regulation 2600.227d SP 07-22-2020

Legal Entity Representative


Signature

DOUGLAS BUTTNER, Ex Dir 1/2/20
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