



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to WILLOW VALLEY COMMUNITIES
LEGAL ENTITY

To operate THE GLEN AT WILLOW VALLEY
NAME OF FACILITY OR AGENCY

Located at 3RD FLOOR, 675 WILLOW VALLEY SQUARE, LANCASTER, PA 17602
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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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 76
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller. (MAXIMUM CAPACITY)

Restrictions: _____

This certificate is granted in accordance with the Public Welfare 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 February 1, 2020 until February 19, 2020,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **321910**

Robert E. Robinson
ISSUING OFFICER

[Signature]
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.



MAILING DATE: January 24, 2020

Ms. Lenore Hutchinson, LPN
Personal Care Home Administrator
Willow Valley Communities
675 Willow Valley Square
Lancaster, Pennsylvania 17602

RE: The Glen at Willow Valley
3rd Floor
Certificate #: 321910

Dear Ms. Hutchinson:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on November 12, 2019 and January 2, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

As the result of your home's recent request to adjust the use of the physical space, the Department has granted an approval for a revised license issued under the authority of 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). The approved capacity revision request is a reduction from 106 to 76 . The Secured Dementia Unit will not have a licensed capacity. The expiration date of the license remains unchanged. The revised license is enclosed.

Since this is a reduction in the previous licensed capacity, you have the right to appeal this decision through a 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, a written request for an appeal must be received within 10 days of the date of this letter by:

Shivani Patel, Enforcement Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-214-1304

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,

A handwritten signature in black ink, appearing to read "Kevin Hancock", written in a cursive style.

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosures
Licensing Inspection Summary
License

Violation Report

Facility Information

Name: *THE GLEN AT WILLOW VALLEY*

License Number: 32191

Address: *675 WILLOW VALLEY SQUARE,, FLOORS 1 AND 3,, LANCASTER, PA 17602*

County: *LANCASTER*

Region: *CENTRAL*

Administrator

Name: *Lenore Hutchinson*

Phone: *7174646870*

Email: *LHUTCHIN@WILLOWVALLEY.ORG*

Legal Entity

Name: *WILLOW VALLEY COMMUNITIES*

Address: *675 WILLOW VALLEY SQUARE, LANCASTER, PA, 17602*

Certificate(s) of Occupancy

Type: *C-1*

Date: *08/05/1995*

Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *65*

Waking Staff: *49*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

11/12/2019 - On-Site: Kellie Cargile, Israel Springs

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106*

Residents Served: *50*

Secured Dementia Care Unit

In Home: *Yes*

Area: *Cedar Brook*

Capacity: *40*

Residents Served: *15*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *50*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *15*

Have Physical Disability: *0*

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 11/9/19, at 12:07 pm, Resident #2's glucometer was used to test the blood sugar level of Resident #3.

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.)

- An Audit was completed to verify each Resident with orders for glucose meter checks had their own glucose meter and that each meter was labeled identifying the Resident name. The audit found each Resident had their own meter and 100% of the meters were properly labeled.
- The staff was reeducated on the Glucose Meter Policy.
- All staff that perform blood sugar checks will complete a competency on glucose meter use in 2020.
- Residents #2 and 3 had blood work for Hepatitis B and C and HIV. The Residents, their physicians, and POAs were notified. Both Resident # 2 and 3 blood work was negative.
- Glucometer audit was completed by the nursing staff the day of the survey 11/12/19.
- Glucometer competencies will be done on 1/14/20 during the diabetic training and on 1/14/20 during the staff meeting.

Legal Entity Representative

Lenore Hutchinson
Signature

Lenore Hutchinson PCHA *12/13/19*
Printed Name and Title Date

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

The above plan of correction is approved as of 1/22/20 Plan of correction implementation status as of 1/2/20
(Date) (Date)

Implemented

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

Not Implemented

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 5/6/19, did not include the resident's body positioning or health status.

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.)

- An audit of the SDU DMEs was completed. It was found 66% (8 out of 12) were found to be incomplete. Of those that were incomplete 100% (8 out of 8) were missing section # 3. Additional 12.5 % (1 out of 8) were missing either section # 4, # 5, # 8, or # 9.
- The SDU nurses were reeducated on regulation 2600.141(a)
- A nursing audit of Resident charts is completed quarterly. Part of the audit process is verifying the DMEs are completed on time and correctly. The audit was reworded for clarity and nursing staff reeducated on how to complete an audit. An admission check list is completed to verify the admission process is complete and timely. The nursing staff was reeducated on this process.
- The administrator will audit each new admission on the SDU to verify compliance.
- The DME audit was completed by the administrator on 12/10/19

Legal Entity Representative

Lenore Hutchinson
Signature

Lenore Hutchinson PCHA 12/13/19
Printed Name and Title Date

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(Date) (Date)

Implemented

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

Not Implemented

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 #1 was admitted to the Secure Dementia Care Unit (SDCU) on 5/6/19. The resident's initial support plan was completed on 5/10/19.

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.)

- An audit of the SDU admission RASPs was complete. It was found that 37.5 % (3 out of 12) of the admission RASP were completed outside of 72 hours.
- The SDU nurses reeducated on regulation 2600.234(a)
- A nursing audit of Resident charts is completed quarterly. Part of the audit process is verifying the assessment and support plans are completed on time and correctly. The audit was reworded for clarity and nursing staff reeducated on how to complete an audit. An admission check list is completed to verify the admission process is complete and timely. The nursing staff was reeducated on this process.
- The administrator will audit each new admission on the SDU to verify compliance.
- The RASP audit was completed by the administrator on 12/10/19

Legal Entity Representative

Lenore Hutchinson
Signature

Lenore Hutchinson PCHA
Printed Name and Title

12/13/19
Date

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(Date)

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