COMMONWEALTH OF 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

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ADDRESS OF SATELLITE SITE ADDRESS OF SATELLITE SITE

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

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 **October 2, 2020** until **October 2, 2021**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **142560**

Robert E. Robinson
ISSUING OFFICER

Jamie L. Buchenauer
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 628 – 6/20

pennsylvania
DEPARTMENT OF HUMAN SERVICES

October 2, 2020

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
License #: 142560

Dear Mr. Coleman:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department), licensing inspections on February 3 and 4, 2020, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Jamie L. Buchenauer

Jamie Buchenauer
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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: *Lori Beltrop* **Phone:** *2155400520* **Email:** *ALCLICENSE@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:** *66* **Waking Staff:** *50*

Inspection

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

Inspection Dates and Department Representative

02/03/2020 - On-Site: Michele Swisher, Natasha Braswell, Alex Goldstein

02/04/2020 - On-Site: Michele Swisher, Natasha Braswell, Alex Goldstein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served:** *33*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Entire Facility* **Capacity:** *48* **Residents Served:** *33*

Hospice

Current Residents: *8*

Number of Residents Who:

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

42c - Treatment of Residents

Regulations

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff person A indicated, during an interview, that they will stand resident #1 in front of their bedroom window to engage or distract the resident while care is being provided. Staff person A reported that resident #1 likes to do this because the resident enjoys looking out into the parking lot at the cars parked there. However, the resident's bedroom does not have any curtains or blinds at the window and the interior of the residents room is clearly visible from outside of the building from the parking lot. This is a violation of the residents right to dignity while receiving care services.

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 suffered no negative effects related to these findings. Resident #1 is not provided personal care in front of window.

Staff person A was re-educated on Resident Dignity and Respect on 2/12/20 by the National Care Delivery Nurse (see attachment 1)

ED and/or designee will re-educate community staff on dignity and respect by 2/27/20 (see attachment 2)

ED and/or designee will audit 5 residents weekly for 4 weeks, then monthly audit for 2 months to ensure they are being treated with dignity and respect while care is provided (see attachment 3, 4)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title Date

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

The above plan of correction is approved as of 08-13-2020 (Date)

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

Plan of correction implementation status as of 08-13-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

42s - Privacy

Regulations

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

Staff person A indicated, during an interview, that they will stand resident #1 in front of their bedroom window to engage or distract the resident while care is being provided. Staff person A reported that resident #1 likes to do this because the resident enjoys looking out into the parking lot at the cars parked there. However, the resident's bedroom does not have any curtains or blinds at the window and the interior of the residents room is clearly visible from outside of the building from the parking lot. This is a violation of the residents right to dignity while receiving care services.

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 suffered no negative effects related to these findings. Resident #1 is not provided personal care in front of window.

Staff person A was re-educated on Resident Dignity and Respect on 2/12/20 by the National Care Delivery Nurse (see attachment 1)

ED and/or designee will re-educate community staff on dignity and respect by 2/27/20 (see attachment 2)

ED and/or designee will audit 5 residents weekly for 4 weeks, then monthly audit for 2 months to ensure they are being treated with dignity and respect while care is provided (see attachment 3, 4)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020
Printed Name and Title — Date

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☒ Implemented
☐ Not Implemented

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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 person B's first day of work was 5/21/2018. Their criminal background check was not completed until 5/23/2018.

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.)

Staff person B has a current criminal background check dated 5/23/18 with no noted criminal offences

ED and/or designee completed a full house audit on current staff on 2/28/20 to ensure current criminal background checks were in place with findings noted. (see attachment 5)

Senior Executive Director conducted re-education to ED and BOM on 2/28/20 regarding proper hiring procedures including the need for criminal background check prior to first day of work. (see attachment 6)

Bom and/or designee will perform audit on 5 new hires weekly for 4 weeks, then monthly for 2 months to ensure criminal background check is completed prior to first day of work. (see attachment 7)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title Date

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- [x] Implemented
- [ ] Not Implemented

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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 C , whose first day of work was 4/2/2019, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services until 6/18/19.

Staff person D , whose first day of work was 7/18/18, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services until 4/17/19.

Staff person E , whose first day of work was 12/6/18, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services until 6/19/19. Repeat et al 08/13/18, 04/17/19

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.)

Staff persons C, D and E received orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services on 6/19/2019 by the National Care Delivery Nurse (see attachment 8)

(Cont on page 2)

65a - FS Orientation 1st Day *(continued)*

Legal Entity Representative

Signature	Jason McDowell Executive Director	3/5/2020
Printed Name and Title	Date

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Plan of correction implementation status as of 08-13-2020 (Date)

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- [ ] Implemented
- [x] Not Implemented

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 C completed his/her 40th scheduled work hour on or about 4/9/19. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, until 6/18/19.

Staff person D completed his/her 40th scheduled work hour on or about 7/23/18. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, until 6/18/19.

Staff person E completed his/her 40th scheduled work hour on or about 12/13/19. However, this staff person did not complete training in the following topics: resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102), reporting of reportable incidents and conditions, until 6/19/19.

Plan of Correction (POC)

Staff Person C, D, and E were trained on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions on 6/19/19 by the National Care Delivery Nurse. (See attachment 8)

On 3/04/2020 the ED and/or designee 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 06/19/2019 employees have received training on Residents Rights, Emergency Medical Plan, mandatory reporting of abuse and neglect and reporting of reportable incidents and conditions. (See attachment 9)

ED trained on 02/27/2020 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 by (Senior Executive Director) (attachment 12)

(Cont on page 2)

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title | Date

(Cont from Page 1. 2600.65.a)

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 (see attachment 8 and 10)

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 8)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative:

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title

65b - Rights/Abuse 40 Hours *(continued)*

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- [ ] Implemented
- [x] Not Implemented

82b - Poisonous Material Storage

Regulations

2600.
82.b. Poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces.

Description of Violation

A container of Micro-kill disinfecting wipes with a manufacturer's label indicating "harmful if swallowed or ingested ", was stored the homes medication cart in a drawer used to store oral medications and nebulizer solutions for residents of 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.)

CSM and/or designee removed container of Micro-kill disinfecting wipes immediately from the med cart on 2/4/2020

CSM completed medication cart review on 02/04/2020 to ensure no other poisonous materials were stored in the home's medication cart drawer, no other materials identified.

CSM and med-techs received re-education regarding regulation 2600 82.b including poisonous materials shall be stored separately from food, food preparation surfaces and dining surfaces by the National Care Delivery Nurse on 02/28/2020 (see attachment 13)

CSM and/or designee will audit medication carts weekly for 4 weeks then monthly for 2 months to ensure poisonous materials are not be stored in the medication carts (see attachment 14)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

X Implemented

☐ Not Implemented

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

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/4/2020 at approximately 1:00pm, there was a large area of brownish red liquid splattered and dried on the wall near the keypad in the D-wing emergency exit area.

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.)

Maintenance Tech and/or designee painted walls in the D-Wing emergency exit area on 2/14/2020

ED or designee completed community round on 02/03/2020 to ensure A,B,C,D,E,F-wing emergency exit areas were free from stains, no other emergency exit areas noted to be affected. (see attachment 15)

Maintenance Tech received re-education regarding regulation 2600 85.a including sanitary conditions shall be maintained and clean in good repair and free from hazards by the ED on 02/27/2020 (see attachment 16)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure sanitary conditions are maintained, including walls free from stains (see attachment 15)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director
Printed Name and Title

3/5/2020
Date

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X Implemented
Not Implemented

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86a - Ventilation

Regulations

2600.
86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

The restroom in the common area/lobby area, has no operable window. There appears to be a vent in the ceiling however the vent/fan does not appear to be providing adequate air flow in the restroom and is in need of repair.

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.)

ED and/or designee notified HVAC service to come in and inspect the ventilation system in the common area/lobby bathroom on 2/7/2020

HVAC Company (Goshen Mechanical) completed an onsite inspection on 02/14/2020 to ensure ceiling vent/exhaust fan was in proper working order. Replacement fan was rewired, aligned and installed. The unit was powered on and tested. Upon completion, the new unit was working properly. (See attachment 17and 18)

Maintenance Tech received re-education regarding regulation 2600 86.a including all areas of the home that are used by the residents shall be ventilated by the ED on 2/27/2020 (see attachment 19)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure vents in the common bathrooms in good repair and free from hazards (see attachment 20)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

90b - Staff Communication

Regulations

2600.
90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The homes system and policy that allows staff in different parts of the home to communicate with each other in an emergency is for staff on duty to carry a walkie radio. On 2/3/2020, staff persons D and F were present on the unit at approximately 2:25pm. Both staff persons did not have walkie radios on them. When inquired as to what the homes policy is, both indicated they are to have a walkie radio on them, but that they did not pick them up from the front desk yet.

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.)

ED and/or designee provided walkie devices to each staff person D and F upon notification on 2/4/2020

ED completed community round on 02/04/2020 to ensure staff members working were in possession of walkie devices with no other staff members noted to be without walkie device.

ED received re-education regarding regulation 2600 90.b including there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency on 02/11/2020 by (Care Services Manager) (see attachment 21)

ED and or/designee will round weekly for 4 weeks then monthly for 2 months to ensure staff members have walkie devices in their procession (see attachment 22)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

X Implemented

☐ Not Implemented

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101j2 - Bedroom Chairs

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
2. A chair for each resident that meets the resident's needs.

Description of Violation

Bedroom B1 is occupied by 2 residents; there are no chairs present in the room. One resident requires the use of a wheelchair, however, there is no other chair present in the room for the second residents 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.)

ED and/or designee examined Bedroom B1 and provided appropriate chair to meet the residents needs on 2/4/2020

ED completed community round on 02/07/20 to ensure occupied resident rooms had the appropriate chair to meet the residents needs. No other rooms noted to be affected. (see attachment 23)

Maintenance Tech received re-education regarding regulation 2600 101.j (2) including a chair for each resident that meets the resident's needs must be present by the ED on 02/28/2020 (see attachment 24)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure resident rooms have the appropriate chairs to meet resident needs (see attachment 25)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason McDonell Executive Director
Printed Name and Title

3/5/2020
Date

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Plan of correction implementation status as of 08-13-2020 (Date)

X Implemented
Not Implemented

101j5 - Bedside Table/Shelf

Regulations

2600.
101.j. Each resident shall have the following in the bedroom:
5. A bedside table or a shelf.

Description of Violation

There is no bedside table or shelf present at the beside in resident room #D3.

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.)

ED and/or designee examined Bedroom D3 and moved the bedside table next to the resident's bed on 2/4/2020

ED completed community round on 02/07/20 to ensure resident rooms had bedside tables or shelf at the bedside as required by regulation 2600.101.j (5) No other rooms noted to be affected. (see attachment 23)

Maintenance Tech received re-education regarding regulation 2600 101.j (5) including a bedsides table or shelf at the bedside for each resident by the ED on 2/28/2020 (see attachment 24)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure resident rooms have bedside tables or shelf at the bedside (see attachment 25)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title | Date

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X Implemented

Not Implemented

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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

Residents in bedrooms D3 and room F4 do 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.)

ED and/or designee examined Bedrooms D3 and F4 and provided an operable lamp that could be turned on at the bedside on 2/4/2020

ED completed community round on 02/07/20 to ensure all resident rooms had an operable lamp that can be turned on at bedside as required by regulation 2600.101.j (7) No other rooms noted to be affected. (see attachment 23)

Maintenance Tech received re-education regarding regulation 2600 101.j (7) including an operable lamp that can be turned on at the bedside by the ED on 02/28/2020 (see attachment 24)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure resident rooms have an operable lamp that can be turned on/off at bedside (see attachment 25)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

101r - Bedroom - shades/drapes/window covering

Regulations

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

The window in bedroom F4 does not have shades, blinds, or shutters.

The window in bedroom D3 has very sheer white curtains across the windows however the parking lot located directly outside of the window is clearly visible through the sheer curtains. This type of curtain does not provide adequate privacy for the resident.

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.)

ED and/or designee examined Bedrooms F4 and D3 and hung window coverings that provided privacy and covered the entire window when drawn on 2/7/2020

ED completed community round on 02/07/20 to ensure all resident rooms had window coverings that provided privacy and covered the entire window when drawn as required by regulation 2600.101.r No other rooms noted to be affected (see attachment 23).

Maintenance Tech received re-education regarding regulation 2600 101.r including there must be drapes, shades, curtains, blinds or shutters on bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn by the ED on 02/27/2020 (see attachment 26)

Maintenance Tech and/or designee will round weekly for 4 weeks then monthly for 2 months to ensure resident rooms have the correct window coverings (see attachment 25)
Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 08-13-2020 (Date)

Plan of correction implementation status as of 08-13-2020 (Date)

☒ Implemented
☐ Not Implemented

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

105g - Lint Removal and Duct Cleaning

Regulations

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2/4/2020, there was an approximate 1/4 inch accumulation of lint in the lint trap of the D-wing laundry room dryer. There were no clothes in the dryer at the time.

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.)

ED removed lint from lint trap in the D-wing laundry room dryer upon notification on 2/4/20

ED and/or designee audited dryers in community to ensure they were free from lint on 02/27/2020, no other dryers noted to be affected. (see attachment 27)

Community staff were in-serviced by National Care Delivery Nurse and Care Services Manager on 2/27/2020 regarding fire hazard risks of lint, as well as lint shall be removed from the lint trap and drum of cloths dryer after each use. (See attachment 28)

Maintenance Tech and/or designee will complete an audit of all dryers to ensure all lint traps are cleaned and free from lint weekly for 4 weeks, then monthly for 2 months. (See attachment 27)

Results of these audits will be reviewed monthly via QA process.

Legal Entity Representative

Signature

Jason P. McDowell Executive Director
Printed Name and Title

3/5/2020
Date

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Plan of correction implementation status as of 08-13-2020 (Date)

X Implemented

☐ Not Implemented

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

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 at the north side patio exit is equipped with a electronic key pad. On 2/4/2020 the code posted near the key pad is incorrect and the gate could not be opened creating a blocked 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.)

ED posted correct code on the exit door at the north side patio on 2/4/20

ED and/or designee audited exit doors on 02/04/2020 to ensure correct code was posted. No other exit doors noted to be affected. (see attachment 29)

Community staff in-serviced that 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, In-service completed on 2/27/2020 by (National Care Delivery Nurse). (See attachment 30)

Executive Director and/or designee will conduct audit of displayed key codes to ensure the code matches with the assigned lock. The audit will be conducted daily for 1 month, then weekly for 4 weeks and monthly for 2 months to ensure compliance. (See attachment 31)

Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

[X] Implemented

[ ] Not Implemented

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

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 2/4/2020, Questran packets prescribed for resident #2, was in the home's medication cart; however, the medication was discontinued on 8/19/19.

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.)

Resident #2 Questran packets were removed and destroyed by licensed nurses on 02/04/2020

CSM and/or designee completed medication cart audit on 02/07/2020 to ensure only current prescription, OTC, sample and CAM for individuals living in the home were kept in medication cart. (see attachment 32)

Licensed Nurses and Med Techs were re-educated on regulations 2600.183.d in regards to only current prescription, OTC, sample and CAM for individuals living in the home were to be kept in medication cart by DCSS and/or designee on 02/27/2020 (see attachment 33)

CSM and/or designee will perform cart to MAR audits on 5 residents weekly for 4 weeks then monthly for 2 months to ensure only current prescription, OTC, sample and CAM for individuals living in the home were to be kept in medication cart. (See attachment 34)
Results of these audits will be reviewed monthly via QA process

Legal Entity Representative

Signature | Jason P McDowell Executive Director — Printed Name and Title | 3/5/2020 — Date

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

The above plan of correction is approved as of 08-13-2020 (Date)

Plan of correction implementation status as of 08-13-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

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 TED's stockings to be placed on residents legs at 8:00 am and removed at bedtime- 8:00 pm. However, on 2/4/2020 at approximately 1:15 pm, the resident did not have the TED's stockings on.

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 suffered no negative side effects from these findings. Resident #3 prescriber was notified of the omission by the CSM on 02/04/2020. (see Attachment 35).

CSM and/or designee reviewed current residents with TED Hose orders on 02/05/2020 to ensure sufficient pairs were available for each resident. No other resident noted to be affected. (see attachment 36)

Licensed Nurses and Med Techs re-educated on regulations 2600.187.d including following prescribers' directions on 02/27/2019 by (National Care Services Nurse) (see attachment 37)

CSM and/or designee will perform audits on 5 residents with prescriber's orders weekly for 4 weeks then monthly for 2 months to ensure prescribers orders are followed. (see attachment 38)

Results of these audits will be reviewed monthly via QA process

Repeat et al 05-16-19

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

- [ ] Implemented
- [x] Not Implemented

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

202 - Prohibitions

Regulations

2600.

202. The following procedures are prohibited:

4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident #4 is prescribed Haldol for anxiety. According to resident progress notes, Haldol is administered to resident 4 to control behaviors. On 12/15/2020, progress notes indicate resident was having increased anxiety and was not easily redirected. on 12/16/2019 a new order for Haldol 1mg by mouth at 8:00 am and 5:00 pm was placed. Residents most recent RASP dated 6/1/19 or most recent DME dated 5/29/2019, contain no indication that resident has a diagnosis or need related to anxiety.

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 Halidol was discontinued by prescriber on 01/23/2020

CSM and/or designee reviewed current residents with Haldol orders on 02/11/2020 to ensure appropriate diagnosis is in place and no chemical restraints are administered. No other residents noted to be affected. (see attachment 39)

CSM re-educated by National Care Delivery Nurse on (02/27/2020) on PA code ch. 2600.202 and the prohibiting of chemical restraints (see attachment 40)

CSM and/or designee will audit 5 residents a week for 4 weeks the monthly for 2 months to ensure they are free from chemical restraints. (See attachment 41)

Results of these audits will be reviewed during QA meeting

Repeat et al 12/09/19

Legal Entity Representative

Signature

Jason P. McDowell Executive Director 3/5/2020

Printed Name and Title Date

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Plan of correction implementation status as of 08-13-2020 (Date)

☐ Implemented

☒ Not Implemented

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

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

On 2/4/2020, the directions for operating the home's locking mechanism to the gate on the North-side patio are incorrect and the gate could not be opened immediately.

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.)

ED posted correct code on the exit door at the north side patio on 2/4/20

ED and/or designee audited exit doors on 02/04/2020 to ensure correct code was posted. No other exit doors noted to be affected. (see attachment 29)

Community staff in-serviced 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. In-service completed on 2/27/2020 by (National Care Delivery Nurse). (See attachment 30)

Executive Director and/or designee will conduct audit of displayed key codes to ensure the code is posted and matches with the assigned lock. The audit will be conducted daily for 1 month, then weekly for 4 weeks and monthly for 2 months to ensure compliance. (See attachment 31)

Results of these audits will be reviewed monthly via QA process

Repeat et al 04/16/19

Legal Entity Representative

Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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Plan of correction implementation status as of 08-13-2020 (Date)

- [ ] Implemented
- [x] Not Implemented

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

251b - Record Entries Legible

Regulations

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on resident's #5 medication administration record for August 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 #5 suffered no negative effects related to these findings

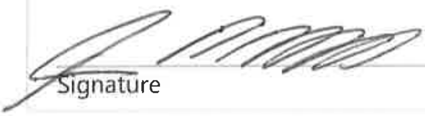
An audit of current resident MAR's was completed by National Care Delivery Nurse and Care Services Manager for the months of December 2019, January 2020 and February 2020 to ensure no correction fluid or tape used on any official medical records or documents. These audits were completed on 2/11/2020. (See attachment 42)

National Care Delivery Nurse and Care Services Manager in-serviced staff on entries in resident records must be permanent, legible, dated, and signed by person making the entry. No white-out or correction tape. Proper documentation correction is to put a line single line through the entry, write "Error" and sign and date correction. This was completed on 2/27/2020. (See attachment 43)

Care Services Manager and/or designee will perform audit of 5 residents MAR's weekly for 4 weeks, then monthly for 2 months to ensure the entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry. (see attachment 44)

-Results of these audits will be reviewed monthly via QA process.

Legal Entity Representative



Signature

Jason P. McDowell Executive Director — Printed Name and Title

3/5/2020 — Date

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

Plan of correction implementation status as of 08-13-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

DEPARTMENT OF HUMAN SERVICES
RECOMMENDATION FOR CERTIFICATE OF COMPLIANCE

REGION S ☒ N ☐ C ☐ W ☐	COUNTY MONTGOMERY
NAME OF LEGAL ENTITY NORTH WALES 1089 MC BG OPCO LLC	TELEPHONE NO. OF LEGAL ENTITY
MAILING ADDRESS OF LEGAL ENTITY 330 N WABASH AVENUE, SUITE 3700, CHICAGO, IL, 60611	
NAME OF AGENCY/FACILITY PARK CREEK PLACE MEMORY CARE	TELEPHONE NO. OF FACILITY 215-540-0520
ADDRESS OF FACILITY 1089 HORSHAM ROAD, NORTH WALES, PA, 19454	

TYPE OF CERTIFICATE	EFFECTIVE DATE (CURRENT CERT.)	IF PRIVATE
☐ New ☐ Renewal ☒ Revision	10-02-2020	☒ Profit ☐ Non-Profit

CERTIFICATE NUMBER	LICENSED CAPACITY	CURRENT CENSUS	TYPE OF CONTROL
142560	48	33	☐ Public ☒ Private

TYPE OF FACILITY AND TYPE OF SERVICE PROVIDED:

REGULATION CHAPTER AND SERVICE TYPE	POPULATION SERVED (INDICATE TYPE: Child, Adult, Geriatric, etc.) (PCH-#SSI,#6o+,#MH,#ID,#MN)
2600	SSI-0, 60+ - 33, MH-0, ID-0, MN- 33

DATES OF INSPECTION	BEO APPROVAL DATE
02-03-2020 AND 02-04-2020	

RECOMMENDATIONS

	TYPE	IF PROVISIONAL
☒ CERTIFICATE RECOMMENDED	☒ Regular ☐ Provisional	☐ First ☐ Second ☐ Third ☐ Fourth

SCORE	PERIOD FROM	TO
	10/2/2020	10/2/2021

	REASON	EFFECTIVE DATE OF ACTION
☐ NEGATIVE SANCTION	☐ Denial ☐ Non-Renewal ☐ Revocation ☐ Voluntary Closure ☐ Other	

BASIS FOR RECOMMENDATION

HOME BEING ISSUED A REGULAR LICENSE. HOME'S PROVISIONAL LICENSE EXPIRED.

Human Services Licensing
Received

10/2/2020

CERTIFICATE OF OCCUPANCY	DATE	ISSUING AUTHORITY/TYPE
☒ YES ☐ NO	C2-LP	L&I

LIST ANY RESTRICTIONS TO CERTIFICATE OF COMPLIANCE (If required by program office)

REVISION OF EXISTING CERTIFICATE OF COMPLIANCE

ITEM (address, capacity, legal entity, other)	CURRENT	NEW	EFFECTIVE DATE OF CHANGE

SIGNATURE/DATE - STAFF MAKING RECOMMENDATION	SIGNATURE/DATE - PROGRAM OFFICE APPROVAL
Shawn Parker 10-02-2020	

RENEWAL APPLICATION FOR EXISTING CERTIFICATE OF COMPLIANCE

APPLICATION IS MADE HEREWITH TO RENEW THE CERTIFICATE OF COMPLIANCE TO OPERATE THE FACILITY/AGENCY TO PROVIDE THE SERVICE SPECIFIED

TYPE OR USE PEN, SIGN AND RETURN

IDENTIFICATION 146106 0070

1. NAME OF AGENCY/FACILITY: PARK CREEK PLACE - MEMORY CARE
TELEPHONE NUMBER: (215) 540-0520

FACILITY ADDRESS: 1089 HORSHAM ROAD, NORTH WALES 19454
E-MAIL FOR FACILITY (NOT the WEB site URL): LegalHelp@enlivant.com ~~ALCLICENSE@ENLIVANT.COM~~
3. COUNTY: MONTGOMERY

2. NAME OF LEGAL ENTITY: NORTH WALES 1089 MC BG OPCO LLC
TELEPHONE NUMBER: (215) 540-0520

MAILING ADDRESS (CORRESPONDENCE TO BE DELIVERED TO): 330 N WABASH AVENUE,SUITE 3700 CHICAGO IL 60611
E-MAIL FOR LEGAL ENTITY (NOT the WEB site URL): LegalHelp@enlivant.com ~~ALCLICENSE@ENLIVANT.COM~~
4. DATE CERTIFICATE EXPIRES: 05/07/2020
5. CERTIFICATE NUMBER: 142561

6. NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE: Matthew Coleman, Authorized Representative

7. TYPE OF SERVICE PROVIDED: PERSONAL CARE HOMES
FEIN OR SSN: 81-3205697

8. REQUESTED/LICENSED CAPACITY (PERSONAL CARE HOMES AND ASSISTED LIVING FACILITIES): 48
Ch # 50046742 $20.00

9. TYPE OF OPERATION
- [x] PROFIT
- [ ] NON-PROFIT

10. TYPE OF OWNERSHIP/CONTROL
- [ ] INDIVIDUAL
- [ ] GOVERNMENT
- [ ] ASSOCIATION
- [ ] SCHOOL DISTRICT
- [ ] PARTNERSHIP
- [ ] CORPORATION
- [ ] FOREIGN PART
- [ ] FOREIGN CORP
- [ ] LLP
- [x] LLC
- [ ] LP
- [ ] OTHER

11. PRIOR LICENSE STATUS

Has the agency/facility (Item 1) or Legal Entity (Item 2), or the Person Responsible (Operator) (Item 6), or the person signing the application ever been denied a Certificate or License, had a Certificate of Compliance or License revoked, or had a Certificate of Compliance or License non-renewed in Pennsylvania or any other state?

- [x] YES (IF YES, EXPLAIN ON SEPARATE SHEET)
- [ ] NO

12. PLEASE ANSWER THE FOLLOWING (IF YES, EXPLAIN ON SEPARATE SHEET)

HAS THE LEGAL ENTITY, OWNER, OR OPERATOR EVER:

		YES	NO
A	BEEN CONVICTED OF A FELONY?	[ ]	[x]
B	BEEN CONVICTED OF A CRIME INVOLVING CHILD ABUSE, CHILD NEGLECT, MORAL TURPITUDE, OR PHYSICAL VIOLENCE?	[ ]	[x]
C	BEEN NAMED A PERPETRATOR IN AN INDICATED OR FOUNDED REPORT OF CHILD ABUSE IN ACCORDANCE WITH THE CHILD PROTECTIVE SERVICE LAW (11 P.S. 2201-2225) OR THE CARE-DEPENDENT SERVICES ACT (18 PA.C.S. 2713)?	[ ]	[x]

13. CURRENT STATUS OF LEGAL ENTITY, OWNER OR OPERATOR

IS THE LEGAL ENTITY, OWNER, OR OPERATOR CURRENTLY CHARGED WITH A FELONY OR MISDEMEANOR?

- [ ] YES (IF YES, EXPLAIN ON SEPARATE SHEET)
- [x] NO

RECEIVED
FEB 11 2020
Human Services Licensing

DECLARATION

Any false information or statement knowingly given in this application is punishable under section 4904 of the PA Crimes Code.

I understand that the Certificate of Compliance will be issued to me on the condition that I will operate the above named facility or agency in accordance with the laws of the Commonwealth of Pennsylvania and with the rules and regulations of the Department of Human Services; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the PA Human Relations Act of 1955; and I hereby declare that the information given in this application is true to the best of my knowledge.

Matthew Coleman
NAME (Type or Print)

[signature]
SIGNATURE OF THE LEGAL ENTITY REPRESENTATIVE
(Where the legal entity is a corporation, the signature must be of a corporate officer.)

Authorized Represenative
TITLE

01/23/2020
DATE

Renewal Application for Existing Certificate of Compliance

Park Creek Place – Memory Care

North Wales 1089 MC BG OPCO LLC

Certificate #142561

Item #11

The Legal Entity Representative set forth on Item 6, Matthew Coleman, has had License #142570 for Park Creek Place – Personal Care located at 1091 Horsham Road, North Wales, PA revoked and replaced with a First Provisional license (expiring 12/20/19) pursuant to that certain letter from the Pennsylvania Department of Human Services dated June 2, 2019. Park Creek Place – Personal Care has submitted correction documentation for all citations set forth on the violation report and is actively working on reinstating the full license.