Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

July 23, 2024

[redacted], CEO
GAHC3 YORK PA ALF TRS SUB LLC
[redacted]

RE: SENIOR COMMONS AT POWDER MILL
1775 POWDER MILL ROAD
YORK, PA, 17403
LICENSE/COC#: 33210

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/22/2024, 05/23/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *01/18/2025*

Address: *1775 POWDER MILL ROAD, YORK, PA 17403*

County: *YORK* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *GAHC3 YORK PA ALF TRS SUB LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/23/2001* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *140* **Waking Staff**: *105*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *05/23/2024*

Inspection Dates and Department Representative

05/22/2024 - On-Site: [redacted]

05/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *104*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Rosewood and Arlington* **Capacity**: *44* **Residents Served**: *26*

Hospice

Current Residents: *26*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *104*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *36* **Have Physical Disability**: *4*

Inspections / Reviews

05/22/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/16/2024*

Inspections / Reviews *(continued)*

06/17/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/21/2024*

06/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/22/2024*

07/23/2024 - Document Submission

Submitted By: [redacted]*ky* **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

63a - First Aid/CPR Training

1. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 05/13/2024, from 11:00PM to 7:00AM, 104 residents were present in the home. During this time 2 staff persons were present in the home who are certified in CPR and First Aid.

On 05/14/2024, from 11:00PM to 7:00AM, 104 residents were present in the home. During this time 2 staff persons were present in the home who are certified in CPR and First Aid.

On 05/15/2024, from 11:00PM to 7:00AM, 104 residents were present in the home. During this time 2 staff persons were present in the home who are certified in CPR and First Aid.

On 05/18/2024, from 11:00PM to 7:00AM, 104 residents were present in the home. During this time 2 staff persons were present in the home who are certified in CPR and First Aid.

Plan of Correction ***Directed ([redacted] - 06/24/2024)***

-Immediate Corrective Action: On 5/24/24, the Assistant Executive Director began reaching out to organizations who perform CPR/First Aid trainings to schedule a training as soon as possible. We will strive to have our first training scheduled by 7/15/24, based on availability of trainers. Following that training session, quarterly sessions will be established on an ongoing basis.
-Additional Corrective Actions: On 5/23/24, the Business Office Director completed an audit to determine all staff needing CPR/First Aid training. Any staff not currently trained will not be counted in the staffing formula to meet this regulation.
-Ongoing Quality Assurance Actions: Beginning with the 3rd quarter of 2024, the Business Office Director will schedule CPR/First Aid training to be available quarterly for all staff. The Business Office Director will review a sample of staff records monthly to ensure ongoing compliance, and to track when training will be due for each staff person. The schedule will be monitored daily by the Clinical Care Coordinator to ensure the minimum required number of staff are CPR/First aid trained. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Proposed Overall Completion Date: 07/15/2024

[Directed]

- *The administrator scheduled the CPR and First Aid Training for 7/17/24. Documentation of this training will be kept and available for review by the Department.*

Directed Completion Date: *07/17/2024*

Implemented ([redacted] - 07/23/2024)

82c - Locking Poisonous Materials

2. Requirements

82c - Locking Poisonous Materials *(continued)*

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 05/22/2024 at approximately 10:35AM, a container of Sani Wipes, with a manufacture's label indicating "contract poison control if swallowed", was unlocked, unattended, and accessible to residents in the Secure Dementia Care Unit (SDCU) kitchenette.

Plan of Correction ***Accept ([redacted] - 06/17/2024)***

-Immediate Corrective Action: On 5/22/24 the Assistant Executive Director removed the sanitary wipes from the unlocked area and placed them in a secure location.
-Additional Corrective Actions: By 7/1/24, all staff will complete poisonous material storage training conducted by Executive Director or Assistant Executive Director.
-Ongoing Quality Assurance Actions: Beginning 7/1/24, care staff will check all common areas at change of shift, to ensure all cleaning supplies and poisonous materials are secured and not accessible to residents. Beginning 5/24/24, the Maintenance Director or Assistant Executive Director will do a daily walk thru of memory care neighborhoods to ensure all poisonous materials are securely stored. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/23/2024)

88a - Surfaces

3. Requirements

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 05/23/2024 at 10:14AM, the upper and lower wooden cabinet doors located in the kitchenette of the dining room were covered with a sticky film.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

-Immediate Corrective Action: On 5/23/24, the Dining Services Director cleaned the area under the juice machine and removed the sticky substance.
-Additional Corrective Actions: By 7/1/24, the Dining staff will be re-trained by the Dining Services Director on the surface cleaning and sanitizing procedure per the Dining Services Manual. The Dining Services Director will ensure completion of the training.
-Ongoing Quality Assurance Actions: Beginning 5/24/24, the Dining Services Director will post the daily cleaning schedule in the dining room and the surfaces will be cleaned after each meal by Dining Staff. The Dining Services Director will complete periodic spot checks of the dining room, and the staff will initial the cleaning schedule after each meal. Ongoing compliance will be discussed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

88a - Surfaces *(continued)*

Implemented ([redacted] - 07/23/2024)

103f - Refrigerator/Freezer Temps

4. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 05/23/2024 at 10:12AM, there was no thermometer located in the freezer or refrigerator sections of the stainless steel "Season's" refrigerator located in the PC dining room kitchenette.

Plan of Correction ***Accept ([redacted] - 06/24/2024)***

-Immediate Corrective Action: On 5/23/24, the Dining Services Director placed a thermometer in the PC refrigerator.
-Additional Corrective Actions: On 5/23/24, the Dining Services Director checked all additional refrigerators in the community to confirm all of them had thermometers. All Dining Services staff will be educated on the regulatory requirement for thermometers in refrigerators by 7/1/24, by the Dining Services Director.
-Ongoing Quality Assurance Actions: Beginning 5/23/24, all refrigerators will be checked daily by the Dining Services Director and documented on the Daily Refrigerator/Freezer Temperature Log. Temperature logs will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/23/2024)

107d - Procedure Emergency Management Agency Submission

5. Requirements

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

Description of Violation

The home's written emergency procedures were not reviewed and sent to the local Emergency Management Agency in 2023.

Plan of Correction ***Accept ([redacted] - 06/17/2024)***

-Immediate Corrective Action: On 6/13/24, the Business Office Director mailed the EMA letter.
-Additional Corrective Actions: On 6/11/24, an Outlook reminder was sent to the Executive Director and Business Office Assistant to send the EMA letter in January 2025.
-Ongoing Quality Assurance Actions: Beginning in January 2025, The Business Office Director will send the letter annually. Confirmation of letter being sent will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *06/14/2024*

Implemented ([redacted] - 07/23/2024)

109b - Rabies Vaccination

6. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 05/22/2024, Resident owned feline named "Abby" was present at the home. The home does not have a current certificate of rabies vaccination. Vaccination for Abby expired on 01/11/2024.

Repeated Violation-02/15/2023, et al

Plan of Correction ***Accept (- 06/17/2024)***

-Immediate Corrective Action: On 5/22/24, the cat was taken by the resident's [redacted] for vaccination and provided to the community a record of vaccination.
-Additional Corrective Actions: On 5/22/24, the Business Office Director completed an audit to verify vaccination records for pets living in or visiting the community.
-Ongoing Quality Assurance Actions: Beginning in July 2024, the Business Office Director will audit resident pet records monthly. Community pet vaccination status will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *06/14/2024*

Implemented (- 07/23/2024)

131a - Fire Extinguisher

7. Requirements

2600.
131.a. There shall be at least one operable fire extinguisher with a minimum 2-A rating for each floor, including the basement and attic.

Description of Violation

On 05/23/2024 at 9:40AM, the was no fire extinguisher in the attic of the home.

Plan of Correction ***Accept (- 06/17/2024)***

-Immediate Corrective Action: On 5/23/24, the Maintenance Director placed a fire extinguisher in the attic space.
-Additional Corrective Actions: Beginning in July 2024, the Maintenance Director will visually verify the presence of a fire extinguisher in the attic during his monthly review.
-Ongoing Quality Assurance Actions: Ongoing compliance will be discussed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *06/14/2024*

Implemented (- 07/23/2024)

144c2 - Smoking Area Distance

8. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

144c2 - Smoking Area Distance *(continued)*

2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On 05/22/2024, at approximately 10:30AM, at least 5 cigarette butts were located on the ground by the trash dumpsters. This is not a smoking location per the home's policy.

Plan of Correction ***Accept (- 06/17/2024)***

-Immediate Corrective Action: On 5/23/24, the Maintenance Director removed and properly discarded the cigarette butts located at the dumpster.
-Additional Corrective Actions: On 5/23/24, 5/29/24 and 6/11/24, the Assistant Executive Director and Executive Director reviewed the community smoking policy at staff meetings.
-Ongoing Quality Assurance Actions: Beginning 5/23/24, the Maintenance Director will visually verify there are no improperly discarded cigarette butts on the property while completing a daily round of the home's exterior. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 07/23/2024)

185a - Implement Storage Procedures

9. Requirements

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

Description of Violation

Resident 1 had the following discrepancies between the Resident's Glucometer and the medication administration record (MAR):
On 05/17/2024, AM blood sugar reading of 65 recorded in MAR was not found in glucometer.
On 05/17/2024, PM blood sugar reading of 92 recorded in MAR was not found in glucometer.
On 05/21/2024, AM blood sugar reading of 293 recorded in MAR was not found in glucometer.

Resident 2 had the following discrepancies between the Resident's Glucometer and the medication administration record (MAR).
On 05/07/2024, PM blood sugar reading of 190 recorded in MAR was not found in glucometer.
On 05/10/2024, PM blood sugar reading of 220 recorded in MAR was not found in glucometer.
On 05/12/2024, PM blood sugar reading of 197 recorded in MAR was not found in glucometer.
On 05/16/2024, PM blood sugar reading of 290 recorded in MAR was not found in glucometer.

Plan of Correction ***Accept (- 06/24/2024)***

-Immediate Corrective Action: On 5/23/24, the Assistant Executive Director met with the Medication Technicians who did not properly document the blood sugar and reviewed proper processes and protocol.
-Additional Corrective Actions: By 7/1/24, the Assistant Executive Director or Day Shift LPN Supervisor will conduct a training with all Medication Technicians regarding shift change responsibilities, which includes review and verification of glucometer readings and documentation. This will be completed at the end of each shift, to ensure

185a - Implement Storage Procedures (continued)

compliance and accurate documentation of glucometer readings.
-Ongoing Quality Assurance Actions: Beginning 7/2/24, Shift Supervisors will verify the Shift Change Responsibilities are being completed. This includes confirming the staff have reviewed and verified glucometer readings and documented them correctly, as recorded on the Shift Change Responsibility Form. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/23/2024)

187d - Follow Prescriber's Orders

10. Requirements

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

Description of Violation

Resident 1 is prescribed Lispro Kiwkpen INJ 100unit/ML inject 1 unit subcutaneously as directed per sliding scale, twice a day at 8AM and 12PM. The sliding scale orders are as follows:
151-200- 2 units
201-250- 4 units
251-300- 6 units
301-350- 8 units
351-400- 10 units
Call for Blood Sugar >400.
On 05/17/2024 at 8:00AM, the resident received 5 units of insulin for a blood sugar level of 65. However, per the sliding scale, the resident shouldn't have received any insulin.
On 05/17/2024 at 12:00PM, the resident received 1 unit of insulin for a blood sugar level of 109. However, per the sliding scale, the resident shouldn't have received any insulin.

Resident 1 is also prescribed a straight order of Lantus Solos INJ 100/ML, inject 14 units subcutaneously twice a day. Per resident's MAR, on 05/14/2024 and 5/15/2024, the resident was administered 13 units instead of 14 units in the AM.

Repeated Violation - 02/15/2023, et al

Plan of Correction ***Accept ([redacted] - 06/17/2024)***

-Immediate Corrective Action: On 5/23/24, the Assistant Executive Director notified Resident 1's PCP. The resident had no adverse effects.
-Additional Corrective Actions: On 5/23/24, the Day Shift LPN Supervisor conducted a training on properly administering sliding scale insulin with the staff who had errors. On [redacted], Resident 1 was admitted to [redacted] hospital and has not yet returned. Prior to their return, all orders will be clarified and the support plan will be updated to reflect that confirmation.
-Ongoing Quality Assurance Actions: Beginning 5/27/24, the Assistant Executive Director will monitor medication administration through weekly EMAR dashboard audits. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

187d - Follow Prescriber's Orders *(continued)*

Implemented (- 07/23/2024)

227g -Support Plan Signatures

11. Requirements

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

Description of Violation

Resident 3 participated in the development of support plan on 01/08/2024. However, the resident did not sign or date the support plan.

Repeated Violation - 02/15/2023, et al

Plan of Correction ***Accept (- 06/17/2024)***

-Immediate Corrective Action: On 5/23/24, the Clinical Care Coordinator obtained the resident signature.
-Additional Corrective Actions: On 5/23/24, Resident 3's chart was audited by the Clinical Care Coordinator to ensure signatures are captured on all necessary documents. Beginning in July 2024, the Clinical Care Coordinator will review a sample of resident records each month as part of the Quality Assurance Program.
-Ongoing Quality Assurance Actions: Beginning 7/1/24, the Assistant Executive Director will complete a 30-day Chart Audit for each new resident. Ongoing compliance will be discussed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 07/23/2024)

254a - Records Discharge/Active

12. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 05/23/2024 at 10:17AM, there was a purple binder labeled "Dinning Book" sitting on a side table unlocked, unattended, and accessible inside the dining room. Inside this binder was a list of all residents with first and last names, room numbers and special diets.

Plan of Correction ***Accept (- 06/24/2024)***

-Immediate Corrective Action: On 5/22/24, the Dining Services Director removed the binder from the dining room and secured it.
-Additional Corrective Actions: Beginning on 5/23/24, the Lead Cook will be responsible for the Resident Roster Binder, including ensuring it is removed from the dining room and secured after meals. All Dining Services staff will be educated by the Dining Services Director on the requirements of this regulation and the importance of confidentiality. Training will be completed by 7/1/24.
-Ongoing Quality Assurance Actions: Beginning 7/1/24, The Dining Services Director will perform periodic spot checks of the dining room, and all staff will be instructed to be vigilant for the security of confidential information. Ongoing compliance will be reviewed at the Quarterly Quality Assurance Meetings, beginning in July 2024.

254a - Records Discharge/Active (continued)

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented ([redacted] - 07/23/2024)