pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **GAHC3 YORK PA ALF TRS SUB LLC**
LEGAL ENTITY

To operate **SENIOR COMMONS AT POWDER MILL**
NAME OF FACILITY OR AGENCY

Located at **1775 POWDER MILL ROAD, YORK, PA 17403**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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 **166**
(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 44**

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 **May 28,** **2025** until **November 28,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **332101**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 28, 2025

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

RE: Senior Commons at Powder Mill
1775 Powder Mill Road
York, Pennsylvania 17403
License/COC #: 332101

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on 2/26/25, 2/27/2025 and 4/22/25 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 20 (relating to Licensure or Approval of Facilities and Agencies, the Department hereby REVOKES your certificate of compliance (license number 33210) dated January 18, 2025 to January 18, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to <62 P.S. § 1026 (b)(1) and 55 Pa. Code § 20.71(a)(2); (4) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 28, 2025 to November 28, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted] Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, Pennsylvania 17105-2675
[redacted]

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,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

Facility Information

Name: *SENIOR COMMONS AT POWDER MILL* **License #**: *33210* **License Expiration**: *01/18/2026*

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**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *148* **Waking Staff**: *111*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/27/2025*

Inspection Dates and Department Representative

02/26/2025 - On-Site: [redacted]

02/27/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *166* **Residents Served**: *109*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *109*

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

Have Mobility Need: *39* **Have Physical Disability**: *3*

Inspections / Reviews

02/26/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2025*

Inspections / Reviews *(continued)*

03/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/10/2025*

05/14/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2025*

Reviewer: [redacted] **Follow-Up Type:**

3c - Post Current License

1. Requirements

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 2/26/25 at approximately 11:00am, the most current LIS dated 12/9/24, and a copy of the 2600-chapter regulation was not conspicuously and publicly posted in the home.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 2/26/25 the LIS dated 12/09/24, a copy of the 2600 regulation book and, current license were placed conspicuously in the lobby by the Executive Director.
Additional Corrective Actions: On 2/27/25 the Business Office Director reached out to BHSL to obtain additional copies of the 2600 chapter regulation book as backup's, should the lobby copy go missing.
Ongoing Quality Assurance Actions: Starting on 4/1/25 a monthly audit will be completed by the Business Office Director, ensuring copies of the most current LIS, a copy of the 2600 regulation book, and current license are conspicuously placed in the lobby. Compliance will be discussed at quarterly QA meetings starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Implemented ([redacted] - 05/01/2025)

15a - Resident Abuse Report

2. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 12/11/24 at approximately 9:30am, staff member A witnessed resident #1, and resident #2 sitting at the dining room table; resident #1 had their hand inside of the front (private) area of resident #2's pants. This allegation of abuse was not reported to the local Area Agency on Aging via the mandatory ACT 13 form.

On 12/11/24 at approximately 5:49pm, staff member B witnessed, resident #1 and resident #3 in resident #1's bedroom. Staff member B also witnessed resident #1 with their hand inside of resident #3's shirt touching the resident's chest area, while resident #3 had their hand inside the front (private area) of resident #1's pants. This allegation of abuse was not reported the local Area Agency on Aging via the mandatory ACT 13 form.

On 2/23/25 at approximately 5:00pm, resident #4 stated while leaving their room, they encountered resident #5 . Resident #4 greeted resident #5 by saying "hello, how are you feeling?" Resident #5, did not verbally respond but hit resident #4 in the upper back with their cane. This allegation of abuse was not reported to the local Agency on Aging via the Mandatory ACT 13 form.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 3/18/25, the Executive Director completed and sent the Mandatory ACT 13 forms to the York County Area Agency on Aging for all three incidents.
Additional Corrective Actions: Training held on 3/18/25 by Executive Director educating the management team on mandatory report requirements to York County Area Agency on Aging office for any alleged abuse.

15a - Resident Abuse Report (continued)

Ongoing Quality Assurance Actions: Starting on 3/18/25 Executive Director will send mandatory ACT 13 form after making verbal report to York County Area Agency on Aging office for any alleged abuse. Ongoing compliance will be discussed while reviewing incidents at quarterly QA meeting starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Implemented ([redacted] - 05/01/2025)

81b - Resident Personal Equipment

6. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 2/27/25 resident #7's bed was observed installed with a Halo ring mobility device. This device was not securely attached and able to fully spin around, thus creating a potential entrapment hazard. In addition, a second Halo ring mobility device was partially removed from the other side of the bed, an uncovered pole to the device was observed sticking up from the bed, posing the risk of injury to the resident.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 2/28/25, Maintenance Director removed Halo Ring Mobility device from Resident #7's bed.
Additional Corrective Actions: On 2/28/25, Maintenance Director checked all residents who use Halo Ring Mobility Device to ensure all are securely attached and in good working order. All found to be working properly, and meet regulatory requirements and our policy.
Ongoing Quality Assurance Actions: Weekly audits will be completed by Maintenance Director, starting on 3/31/25 to ensure all Halo Ring Mobility devices are in good working order. Repair to device will be made when necessary and findings will be discussed at quarterly QA meeting starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Not Implemented ([redacted] - 05/01/2025)

101j7 - Lighting/Operable Lamp

8. Requirements

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

On 2/27/25, resident's #8 and #9 did not have access to a source of light within reach that can be turned on/off at bedside.

Plan of Correction ***Accept (- 03/26/2025)***

Immediate Corrective Action: On 2/28/25, the Maintenance Director placed a lamp within reach of resident at bedside.
Additional Corrective Actions: Maintenance Director completed audit of resident rooms on 2/28/25 to ensure all residents had access to a light source within reach at bedside.
Ongoing Quality Assurance Actions: Weekly audit beginning on 3/31/25 to be completed by the housekeeping staff to ensure all residents have access to a source of light within reach at bedside. Findings to be discussed at quarterly QA meeting starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Implemented (- 05/01/2025)

182b - Prescription Medication

9. Requirements

2600.
182.b. Prescription medication that is not self-administered by a resident shall be administered by one of the following:
1. A physician, licensed dentist, licensed physician's assistant, registered nurse, certified registered nurse practitioner, licensed practical nurse or licensed paramedic.
2. A graduate of an approved nursing program functioning under the direct supervision of a professional nurse who is present in the home.
3. A student nurse of an approved nursing program functioning under the direct supervision of a member of the nursing school faculty who is present in the home.
4. A staff person who has completed the medication administration training as specified in § 2600.190 (relating to medication administration training) for the administration of oral; topical; eye, nose and ear drop prescription medications; insulin injections and epinephrine injections for insect bites or other allergies.

Description of Violation

On 12/7/24 staff member C administered a Mucinex Tablet to resident #10. Staff member C was not trained in medication administration.

Plan of Correction ***Accept (- 03/26/2025)***

Immediate Corrective Action: On 12/7/25, Staff Member C was counseled that only certified Medication

182b - Prescription Medication (continued)

Technicians (Med-Tech's) are able to give a resident prescribed medication. Additionally, the Mucinex was removed from Resident 10's room and given to the family, by the Assistant Executive Director.
Additional Corrective Actions: On 12/7/25, Wellness nurse confirmed that Resident 10 had order for Mucinex for Med-Tech's to administer.
Ongoing: On 3/19/25 LPN supervisor held a staff meeting educating staff that only Med-Tech's are able to pass medications. Ongoing compliance will be discussed at quarterly QA meeting starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Implemented ([redacted] - 05/01/2025)

183b - Meds and Syringes Locked

10. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 2/27/25 at approximately 11:43am, a tube of moisture barrier antifungal cream/Miconazole cream was unlocked, unattended, and accessible on the bathroom sink in resident #7's bedroom.

On 2/27/25 at approximately 11:50am, a container of Tums and tube of CVS medicated chest rub topical analgesic was unlocked, unattended, and accessible above the toilet in resident #11's bathroom.

On 2/27/25 at approximately 12:15pm, a container of Tums was unlocked, unattended, and accessible on the desk in resident #5's bedroom.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 2/27/25 Assistant Executive Director removed all medications noted from Resident 7, 11 and 5's rooms.
Additional Corrective Actions: Room audit completed by Assistant Executive Director on 3/31/25 for sample of resident rooms. No additional medications found during audit
Ongoing Quality Assurance Actions: Starting on 3/31/25, weekly room audit to be completed by housekeeping to ensure residents do not have medications in their room, unattended and accessible. Findings to be discussed at quarterly QA meeting starting on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Not Implemented ([redacted] - 05/01/2025)

185a - Implement Storage Procedures

12. 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 #12's glucometers were cross-referenced with the MAR resulting in the following:

- *On 2/16/25 at 3:52am the Freestyle Libre glucometer shows a reading of 256; the MAR shows a reading of*

185a - Implement Storage Procedures (continued)

265 at 5:00pm

- *On 02/17/25 the Presto glucometer shows a reading of 300 @3:02am; the MAR did show not this reading.*
- *On 02/20/25 the MAR shows a reading of 147 at 8:00am; neither glucometer shows this reading.*
- *On 02/23/25 the MAR shows a reading of 183 at 8:00am; neither glucometer shows this reading.*
- *On 02/24/25 the glucometer shows a reading of 254 at 7:27am; the MAR show a reading of 245 at 8:00am.*
- *On 02/24/25 the Presto glucometer shows a reading of 190 at 9:16am; the MAR does not show this reading.*
- *On 02/26/25 the Presto glucometer shows a reading of 254 at 3:18pm; the MAR shows a reading of 251 at 5:00pm.*
- *On 2/26/25 the Presto glucometer shows a reading of 145 at 9:15am; the MAR did not show this reading.*

Resident #13 is prescribed Lidocaine 4% apply topically to left knee daily, and hip area right side at bedtime, for pain. However, the medication was not available in the home.

Repeated Violation- 5/22/24, et al

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 3/21/25, the Assistant Executive Director met with the Med Techs and reviewed proper processes and protocol. Also, on 2/28/25 Resident 13's Lidocaine 4% was ordered and applied to resident's right side at bedtime.

Additional Corrective Actions: By 3/31/25, the Assistant Executive Director or Day Shift LPN Supervisor will conduct a training with all Med Techs 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 compliance and accurate documentation of glucometer readings. Additionally, during shift change, Med Techs will review medications orders that are pending to ensure medications are arriving to the community timely.

Ongoing: Beginning 3/31/25, 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. Additionally, Med Techs will review pending orders to ensure residents medications are arriving timely to the community. Ongoing compliance will be reviewed at the Quarterly QA Meetings, beginning 4/8/25

Licensee's Proposed Overall Completion Date: *04/08/2025*

Not Implemented ([redacted] - 05/01/2025)

186b - Medication Used by Resident

13. Requirements

2600.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 6/7/24 at 9:00am, resident #2 consumed a smoothie containing medication belonging to resident #14, due to staff not monitoring closely.

On 10/18/24 at 8:00pm, resident #15 was administered Carb/Levo 25-250mg, Donepezil 5mg, and Quetiapine 25mg by staff, however the medication belongs to resident #16.

186b - Medication Used by Resident *(continued)*

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 6/7/24 and 10/18/24 Resident's 2 and 15's PCP's were notified of the error and state reportable incident was sent to DHS by the Assistant Executive Director.
Additional Corrective Actions: Staff followed PCP orders to monitor Resident 2 and 15. Staff was ordered to contact PCP's if residents experienced any adverse affects. No adverse affects noted for Resident 2 or 15. Medication training on 3/19/25 by LPN supervisor to review medication standards.
Ongoing: Ongoing compliance will be discussed at quarterly QA meeting beginning on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Implemented ([redacted] - 05/14/2025)

187a - Medication Record

14. Requirements

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

Description of Violation

Resident #2 is prescribed eye relieve dry advanced instill 1 drop in both eyes four times a day. However, the diagnosis or purpose of medication was not listed on the medication administration record.

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 2/28/25, the LPN Supervisor requested the PCP clarify the order for Resident 2's dry eye relief drops to list the diagnosis/purpose.
Additional Corrective Actions: Resident 2's chart was audited to ensure all medications had a diagnosis/purpose listed on the Medication Administration Record.
Ongoing: A sample of resident records will be audited monthly by the Clinical Care Coordinator to ensure diagnoses are listed on the residents' Medication Administration record beginning in April, 2025. Audit findings will be discussed at the quarterly QA meetings beginning on 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Not Implemented ([redacted] - 05/01/2025)

187d - Follow Prescriber's Orders

15. Requirements

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

Description of Violation

*Resident #12 is prescribed Aspart 70/30 3ML Pen Inject 28 Units subcutaneously every evening ***Hold Insulin for blood sugar less that 75** for DM. On 2/11/25, at 3:39pm the residents blood sugar reading was 95; however, 28 units were not injected, stating "held for parameters."*

- *On 12/19/24, resident #10 did not receive [redacted] Gabapentin in the morning and at bedtime, nor the morning dose on 12/20/24.*
- *On 12/23/24, resident #17 did not receive [redacted] Albuterol Nebulizer in the morning and in the afternoon.*

187d - Follow Prescriber's Orders (continued)

- *On 12/23/24 at 9:00pm resident #12 did not receive [redacted] Lorazepam Gel.*
- *On 12/24/24 and 12/25/24 resident #18 did not receive [redacted] Omeprazole in the morning.*
- *On 12/25/24, resident #19 did not receive [redacted] Levothyroxine or Pantoprazole in the evening.*
- *On 12/25/24, resident #20 did not receive [redacted] Lorazepam at bedtime.*
- *On 12/25/2024 at bedtime and 12/26/24 in the morning, resident #21 did not receive [redacted] Lidocaine Pad.*
- *On 12/25/2024, resident #22 did not receive [redacted] Cephalexin at bedtime.*
- *On 12/25/2024, resident #23 did not receive [redacted] Atorvastatin in the evening.*
- *On 12/26/2024, resident #24 did not receive [redacted] Metformin, Memantine, nor Escitalopram in the morning.*

Repeated Violation- 5/22/24, et al

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Immediate Corrective Action: On 3/17/25 Assistant Executive Director reported to DHS that Resident 12 did not receive 28 units of insulin on 2/11/25. It was documented the dose was held for parameters, when it should have been given due to the documented blood sugar reading being above 75.
-PCP's, DHS and Families were notified within 24 hours of community learning of missed medications by Assistant Executive Director. Residents all monitored for adverse affects, none noted.
Additional Corrective Actions: Med-Tech training held on 3/19/25 to review medication standards by LPN Supervisor.
Ongoing: Starting on 3/31/25, Med-Techs will complete shift change responsibility form after each shift to ensure residents medications are in-house to be given. Med-Tech's will immediately notify Shift Supervisor or Lead Med-Tech to assist with any medication issues. Findings will be discussed at quarterly QA meeting starting 4/8/25.

Licensee's Proposed Overall Completion Date: *04/08/2025*

Not Implemented ([redacted] - 05/01/2025)