



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
100 LACKAWANNA AVENUE
ROOM 330, SCRANTON STATE OFFICE BUILDING
SCRANTON, PENNSYLVANIA 18503-1923

ADULT RESIDENTIAL LICENSING

PHONE: (570) 963-3209
1-800-833-5095
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Sent via email to: [REDACTED]

MAILING DATE: August 30, 2011

Mr. Joseph O. Negrao, President
Alexandria Manor of Allentown, Inc.
7 South New Street
Nazareth, Pennsylvania 18064

RE: Alexandria Manor of Allentown-Bethlehem Campus
3534 Linden Street
Bethlehem, Pennsylvania 18017

Dear Mr. Negrao:

As a result of the Department of Public Welfare's licensing inspection on July 22, 2011 of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.


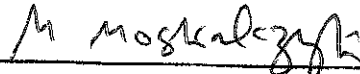
All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.


Sincerely,

Michele Moskalezyk
Regional Licensing Administrator

Enclosure
Violation Report

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME ALEXANDRIA MANOR OF ALLENTOWN BETHLEHEM CAMPUS, 3534 LINDEN STREET BETHLEHEM, PA 18017		CURRENT LICENSE NUMBER 214560		
INSPECTION DATES (Include all dates of the inspection) 07/22/2011		REGIONAL REPRESENTATIVE Meriann O'Malley		
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) DAVID A. SMITH, ASSIST. ADMIN.				
SIGNATURE OF LEGAL ENTITY 		DATE 8/29/11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION 	DATE 8.29.11

REGULATION 55 Pa.Code §2600	VIOLATION	DATE COMPLIANCE VERIFIED BY	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
16c The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).	<p>On 06/24/2011, Resident #1 was taken by ambulance to St. Luke's Hospital for injuries to the right forehead and right eye. The home did not file an unusual incident report with the department as is required when a resident suffers a physical trauma that requires treatment at a hospital. The Home failed to submit a reportable Incident form to the Department's N.E. Regional Office as required.</p> <p>On 07/13/2011, the Bethlehem police were dispatched to the home to respond to a theft complaint. The police report indicates an officer arrived at the home, and investigated a report from staff member A that (6) 5/325MG oxycodone [sic] pills were missing. The Home failed to submit a reportable Incident form to the Department's N.E. Regional Office as required</p> <p>On 07/14/2011, Staff member D advised by staff member A that staff member C took a photograph of resident #1, without the permission of the resident. The Home failed to submit a reportable Incident form to the Department's N.E. Regional Office as required.</p>	8/29/11	<p align="center">16c - 6/24/2011</p> <p>All residents will be sent to the hospital for evaluation/treatment for a physical trauma suffered. Admin Staff & PCA Staff will send any resident who falls to the hospital. All Residents have been spoken to about using callbells/ambulatory devices @ all times that assistance is required. Reportable Incident(s) will be faxed to DPW within 24 hrs of the incident by the Admin Staff. PCA Staff does not need the permission of Admin Staff to send a resident out for any observation/treatment, Admin shall be notified when a resident is sent out & upon return. **See attached marked 16c**</p>	<p align="center">Steps have been taken to correct violation, full compliance is not verifiable</p> <p>Date: 8/29/11 Initials (DPW): </p>

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SIGNATURE OF LEGAL ENTITY <i>DA Smith</i>	DATE 8/29/11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>M. Mostkalezyk</i>	DATE 8.29.11

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16c continued		8/29/11	<p>16c - 7/13/2011 Reportable incident was faxed to DPW on 7/13/11 @ 4:20pm & was misfiled into one of our other Alexandria Manor files at DPW at which time we were told to disregard this violation by Meriann O'Malley of DPW.</p> <p>16c - 7/14/2011 First Admin Staff knew of photo being taken was when D told A on 7/14. Offending PCA was released from duty on 7/11/11. No way to prove photo was taken. HIPPA policy was signed by ALL Staff. **See attached** Any staff seeing unauthorized photo's being taken will inform Admin Staff immediately & Incident Report sent to DPW.</p> <p>The administrator will monitor all incident reports and assure compliance with this regulation. <i>M. Mostkalezyk</i> 8/29/11</p>	<p>Continue from previous page -</p> <p>Steps have been taken to correct violation; full compliance is not verified. Date: 8/29/11 Initials (DPW): <i>MMW</i></p>

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42i A resident shall receive assistance in accessing health services.	<p>Night shift staff reported finding Resident #1 on the floor at approximately 5:00AM on or about 06/24/2011. Night shift reported the fall to the oncoming day shift at approximately 6:30am and also communicated the information through the Home's shift report and internal incident reporting system. The verbal and written reports included that Resident #1 hit the right side of forehead, and had abrasions on both knees.</p> <p>Staff member interviews determined that at approximately 7:30AM, bruising and swelling of the right eye was observed, and Staff member A was asked to come and evaluate resident. At approximately 8:40AM, Direct Care Staff again reported to staff member A, and requested that resident #1 be sent to the hospital.</p> <p>At approximately 11:30AM, Direct Care asked Staff member B, if they could call an ambulance for Resident #1, because the resident's right eye had swollen shut, and the right head and eye area was very bruised and swollen. According to staff interviews, the resident was slumped over and in a wheelchair at that time, and was not easily roused. Staff member B declined to allow direct</p>	8/29/11	<p>42i</p> <p>All Staff are informed at interview about "When in doubt, send them out" Policy</p> <p>There has never been a need for permission to send a resident out for treatment.</p> <p>Prevention: Going forward:</p> <p>Staff has be re-trained and documented form created on this policy for each employee to sign including the proper steps to follow on sending resident out. This form will be found in all PCA Staff file.</p> <p>**See attached**</p> <p><i>The administrator or designee will be responsible to monitor for compliance of this regulation</i></p>	<p>Steps have been taken to correct violation, full compliance is not verifiable</p> <p>Date: <i>8/29/11</i></p> <p>Initials (DPW): <i>M. Moskalezyk</i></p>

M. Moskalezyk
8/29/11

0005/0019

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SIGNATURE OF LEGAL ENTITY <i>J. Smith</i>	DATE 8/28/11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>M. Moskalczyk</i>	DATE 8/29/11

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	<p>care workers to call for an ambulance, and indicated they would get to it.</p> <p>At approximately 2PM, staff member A was again asked by direct care staff to evaluate Resident #1. Staff member A called an ambulance and resident #1 was taken into St Luke's Hospital at 2:07PM. From the emergency room, resident #1 was admitted for treatment of encephalopathy, secondary to a traumatic head injury. The home did not provide timely and reasonable access to emergency medical care as required.</p>	8/29/11		Cont. from prev. page.


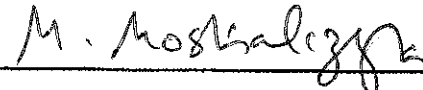
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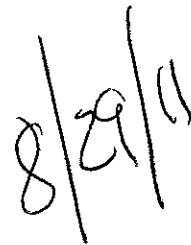
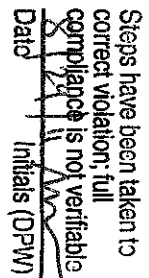
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		DATE 8/29/11

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42s 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.	On 06/24/2011, Staff member C took a photo of Resident #1 without the resident's consent. During an interview on 07/14/2011, Staff A reported to Northampton county Area Agency on Aging Protective Services worker that it was discovered that staff member C took a photo of a resident #1 without the resident's consent. This is a violation of the resident's right to privacy.	<i>8/29/11</i>	<p align="center">42 S</p> <p>Staff D reported to Area Agency on Aging at the same time Admin Staff was 1st notified about Staff C photographing Resident #1. Since staff C was released from her duties on 7/11/11 there is no way to prove that a photo was taken. Staff D was told that a photo was taken but did not actually see her taking it or photo itself. <u>Staff has been retrained on Privacy Practices @ Alexandria Manor, and signed documentation appears in employees file & Admin will ensure practice is followed.</u></p> <p align="center">**See attached**</p>	<p>Steps have been taken to correct violation, full compliance is not verifiable</p> <p>Date <i>8/29/11</i> Initials (DPM)</p>

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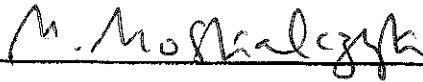
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124 The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.	The home did not notify the fire department of resident #1's change in mobility needs that occurred on 12/29/2010 when a physical/occupational therapy evaluation by HRC Manor Care and the HRC's overseeing physician determined a severe gait and balance disturbance prohibited the resident from independent ambulation. The physical therapist and physician also determined that due to dementia and unfamiliarity with a new walker, resident #1 could not safely use a walker and could not self propel a wheelchair.		124 No way to correct 2010 notification now. <u>Moving forward:</u> Fire Dept will be notified in person, or by fax, when our roster and the residents mobility needs change. Admin Staff will ensure notification is updated & provided to proper authorities with copies attached in the DPW inspection Book for review. **See attached Updates**	Steps have been taken to correct violation; full compliance is not verifiable  Date _____ Initials (DPW)

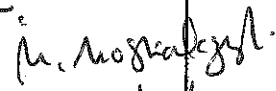
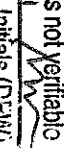
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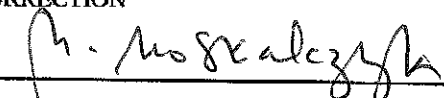
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141b2 A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.	The emergency evacuation mobility needs of Resident #1, admission date 12/11/2010, was listed as "walks without assistance" on the resident's Medical Evaluation dated 12/07/2010. Staff interviews and physical therapy notes from 12/28/2011 HRC Manor Care indicate resident was determined to be a severe fall risk shortly after admission. Those records indicate Resident #1 was hospitalized on at least two occasions for weakness and head injury secondary to a fall several weeks after admission. The home's staff and HRC Manor Services documentation indicated that resident #1 was unable to effectively use a walker, or walk safely without maximum verbal cues and physical assistance from staff. On 02/18/2011, Resident #1's primary care physician signed a physician's order that stated the resident's mobility limitation prevented the resident from accomplishing any mobility related activities of daily living. The home did not update the resident's medical evaluation and mobility status until 06/28/2011.	8/29/11	<p align="center">141b2</p> <p>Weekly meetings are now held with Bayada & HRC Manor Care & Alexandria Manor Administrator to discuss the residents needs, concerns and their changes.</p> <p><u>Moving forward:</u> Administrator will ensure that all required paperwork, evaluations are updated as the need arises in a timely manner and placed in residents chart.</p> <p><i>The administrator will be responsible for retaining all correct paperwork.</i> <i>M. O'Malley</i> 8/29/11</p>	<p align="center">Steps have been taken to correct violation, full compliance is not verifiable</p> <p>Date: <i>8/29/11</i> Initials (DPW): <i>MO</i></p>

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225c The resident shall have additional assessments as follows: (1) Annually. (2) If the condition of the resident significantly changes prior to the annual assessment. (3) At the request of the Department upon cause to believe that an update is required.	According to HRC Manor Services documentation and staff member interviews, resident #1, date of admission 12/11/10, had been injured due to several falls shortly after the resident was admitted to the home. Direct care staff related that resident was very unsteady and the staff responded by continually asking the resident to remain seated in a wheelchair. Staff would take resident to supervised areas to prevent further falls. HRC Manor Services began to provide physical and occupational therapy on 12/28/2010. On 01/13/2011, HRC Manor Services documented that resident #1 was unable to independently use a walker, or safely walk without assistance. On 02/18/2011, Resident #1's primary care physician signed a physician's order that stated the resident's mobility limitation prevented the resident from accomplishing any mobility related activities of daily living. On 03/03/11, physical therapy was discontinued because of lack of improvement. Bayada home nursing service evaluation was completed on 6/15/11. The Bayada nursing	8/29/11	225c New Med Eval, Assessments & Support Plan were done for resident #1. Moving forward: New Med Eval, Assessment & Support Plans will be updated as significant changes occur for the residents and placed in the residents chart by Admin Staff. The administrator will assure compliance with this regulation.  8/29/11	Steps have been taken to correct violation; full compliance is not verifiable Date: 8/29/11 Initials (D-P/W): 

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	assessment and supervising physician indicated resident was unable to get herself out of bed or stand from a sitting position. Resident #1 was described as being "wheelchair bound" and at severe risk of falls. The evaluation and nursing plan included caring for wounds resident #1 sustained during falls, monitoring heart irregularities, oxygen saturation, and caregiver teaching. Resident #1's assessment dated 12/08/2010 was not updated to reflect the changes in the resident's mobility status or the implementation of home nursing care and physical therapy as mentioned above.	8/29/11		Cont from previous page