



**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE**

11 Stanwix Street  
Room 230  
Pittsburgh, Pennsylvania 15222

**ADULT RESIDENTIAL LICENSING**

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[www.dpw.state.pa.us](http://www.dpw.state.pa.us)

Mailing Date: MAR 16 2012]

Mr. Philip M. Ripepi, NHA  
CPSR Associates, LLC  
500 Lewis Run Road  
Pittsburgh, PA 15122

RE: Mon Valley Care Center  
200 Stoop Drive  
Monongahela, PA 15063

Dear Mr. Ripepi:

As a result of the Department of Public Welfare's licensing inspection on November 2, 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,

A handwritten signature in black ink, appearing to read "Janine Wenzig".

Janine Wenzig  
Regional Licensing Administrator

Enclosure(s)

NAME AND ADDRESS OF PERSONAL CARE HOME MON VALLEY CARE CENTER, 200 STOOPS DRIVE MONONGAHELA, PA 15063		CURRENT LICENSE NUMBER 418160
INSPECTION DATES (Include all dates of the inspection) 11/02/2011	REGIONAL REPRESENTATIVE M. Stepanovich	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan)		
SIGNATURE OF LEGAL ENTITY <i>Damon Hill RN/PCA</i>	DATE 1/3/2012	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>
		DATE 2/5/12

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
42c A resident shall be treated with dignity and respect.	On 10/19/11 at 2:45 PM, resident #1 needed assistance playing Pokeno with other residents. However, staff person A informed resident #1 that he/she would need to move to another table, which the resident was not in favor of, to receive staff assistance. If the resident didn't move, staff was not going to assist him/her. These comments caused the resident to cry and go to his/her room. Also, staff person A stated he/she was not going to take residents to activities, because they have an activity calendar and should know when activities are scheduled.	10/20/11 <i>Bay</i> 4/15/12	Staff person A was terminated on on going training regarding residents rights, abuse, treating residents with dignity & respect AS PER REGULATION 42C WILL CONTINUE. <i>on 3-14-12 Administrator will interview residents monthly for 6 months to ensure residents rights are being respected.</i> Resident #2 Enabler was removed until family can purchase an enabler to meet regulation 81b requirements. Resident Co-ordinator will assist with this process, and monitor any further enablers meet requirements of regulation 81b.	Steps have been taken to correct violation; full compliance is not verifiable <i>2/5/12</i> Date <i>[Signature]</i> Initials (DPV)
81b Wheelchairs, walkers, prosthetic devices and other apparatus used by residents shall be clean, in good repair and free of hazards.	Repeated Violations: 07/11/2011 Resident #2's enabler, which was not securely attached to the bed, had an approximate 7-8" wide opening that did not have a cover.			<i>[Signature]</i> 2/5/12

RECEIVED