



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
Norristown State Hospital
1001 Sterigere Street
Bldg 2 Rm. 161
Norristown, Pennsylvania 19401

ADULT RESIDENTIAL LICENSING

1-866-711-4115
610-270-1137

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
Mailing Date: March 12, 2012

Mr. Frank Beech, NHA
Dunwoody Village, Inc.
Attn: Personal Care Services
3500 West Chester Pike
Newtown Square, Pennsylvania 19073

Re: Dunwoody Village

Dear Mr. Beech:

As a result of the Department of Public Welfare's licensing inspection on November 29, 2011, November 30, 2011 and December 9, 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 that reads "Chevon Miller".

Chevon Miller
Regional Licensing Administrator

Enclosure(s)
Violation Report

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

NAME AND ADDRESS OF PERSONAL CARE HOME DUNWOODY VILLAGE, 3500 WEST CHESTER PIKE NEWTOWN SQUARE, PA 19073		CURRENT LICENSE NUMBER 145250	
INSPECTION DATES (include all dates of the inspection) 11/29/2011, 11/30/11 & 12/2/11		REGIONAL REPRESENTATIVE Christine McHale, Lori Knockstead	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) MARY McGoldrick RN PC ADMINISTRATOR			
SIGNATURE OF LEGAL ENTITY <i>Mary McGoldrick</i>	DATE 1-19-12	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>	DATE 3/6/12

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	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).	On 11/19/11, Staff person A reported to administrators at the home an allegation of abuse towards resident #1. The home did not submit an incident report to the Department until 11/23/11. Staff person B stated that the home did not report this incident sooner because "nobody suspected any foul play at the home."	1-19-12 Violation 16c. DATE CORRECTED: 1/8/12	<p>Violation, 16c. Dunwoody Village (as your report reads, the "Home") asserts that there are several inaccuracies with the facts as portrayed by the Department of Public Welfare (as your report reads, the "Department") Regional Licensing representatives. The Home also affirms that the delay in reporting this incident to the Department did not cause harm, distress or delay in care to Resident #1. For the record, once the Home did make a report to DPW, it took seven days for a representative to visit with the resident.</p> <p>For the purpose of transparency and public reporting, Dunwoody Village wishes to clarify the following facts that are portrayed differently by the Department of Public Welfare in this violation report. This incident occurred on Saturday, 11/19/10 at approximately 11am. Staff person "A" did not report an allegation of abuse towards resident #1. Staff person "A" felt that she had witnessed something that she should report to her supervisor. Following facility protocols, the supervisor immediately began an internal investigation and notified via telephone, the Personal Care Administrator (PCA) and the Director of Nursing (DON). With the facts gathered at this time, the PCA and DON, via a conference call, felt that no "foul play" or "suspicion" of abuse occurred. The DON telephoned Staff person "B", the facilities Director of Health Services (NHA) to discuss the incident. The DON and NHA agreed that no "foul play" or "suspicion" of abuse occurred. As a result, the facility did not notify any state agencies. This violation states that the "Home" did not report the incident to the Department until 11/23/11. This is inaccurate; the "Home" did notify the Department on 11/22/11 as well as the Area Office of Aging as reported on the ACT 13 form submitted by the facility.</p>	<p>Steps have been taken to correct violation; full compliance is not verifiable</p> <p>3/6/12 MBC Date Initials (DPW)</p>

Continued on next page

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

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PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <i>MARY McGoIdrick RN PC ADMINISTRATOR</i>			
SIGNATURE OF LEGAL ENTITY <i>Mary McGoIdrick</i>	DATE <i>1-19-12</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>JL</i>	DATE <i>3/12/12</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	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).	On 11/19/11, Staff person A reported to administrators at the home an allegation of abuse towards resident #1. The home did not submit an incident report to the Department until 11/23/11. Staff person B stated that the home did not report this incident sooner because "nobody suspected any foul play at the home."	<i>1-9-12</i>	Dunwoody Village's senior management spent considerable time examining various State reporting requirements for abuse reporting. On January 1, 2012, new Adult Residential Licensing (ARL) regulations became effective and on page 181 of 55 Pa. Code Chapter 2600, there is a clear flow chart which indicates reporting requirements and time frames. The Home used this tool and trained its Personal Care staff on DPW's "Suspected Resident Abuse Reporting and Investigation Requirements." This training occurred on the following dates: 12/14/11 and 1/11/12. The Home updated its internal policies and procedures to reflect the 1/1/12 changes. All staff are trained at new hire orientation and annually on abuse training and reporting. The Home will now require that volunteers attend this same training. Upon the facilities investigation, we learned that the Ombudsman's office does not train its volunteers on Resident Abuse. As part of our POC, we will suggest to the Ombudsman office that they consider training all volunteers on DPW's "Suspected Resident Abuse Reporting and Investigation Requirements." that became effective January 1, 2012. This way all persons involved with seniors at the State and local levels receive consistent training so that all residents are protected from abuse in a consistent manner. On December 9, 2011, the licensing representatives provided the PCA and NHA with two handouts consisting of training provided to DPW personnel from Temple University's Institute on Protective Services regarding abuse identification and efficient investigations. The Home has used these training materials (on 1/11/12) to train its senior staff on more advanced techniques regarding abuse identification and investigation. Lastly, the Home will suggest to DPW's Director and Deputy Secretary that the State make available these training materials to all Personal Care homes so that all PCA's and NHA's have relevant, consistent and current information regarding abuse reporting and its timelines.	

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 Mary McGoIdrick
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SIGNATURE OF LEGAL ENTITY <i>Mary McGooldrick</i>	DATE 1-19-12	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>LM</i>	DATE 3/6/12

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15a 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.	On 11/19/11, an allegation of abuse against resident #1 was reported by staff person A. The home did not report the allegation to the local area agency on aging, the State Department of Aging, or the police until 11/23/11. Staff person B stated that the home did not report this incident sooner because "nobody suspected any foul play at the home."	1-9-12	<p>Violation 15a.</p> <p>Violation 15a is principally the same violation as 16c for which the Home is already being cited for in this report. Due to the Department's conclusion, Volunteer/Ombudsman "C" is banned from the Home's campus. However, Volunteer/Ombudsman "C" and Resident #1 may meet together off campus at the discretion of the families.</p> <p>Dunwoody Village (as your report reads, the "Home") asserts that there are several inaccuracies with the facts as portrayed by the Department of Public Welfare (as your report reads, the "Department") Regional Licensing representatives. The Home also affirms that the delay in reporting this incident to the Department did not cause harm, distress or delay in care to Resident #1. For the record, once the Home did make a report to DPW, it took seven days for a representative to visit with the resident.</p> <p>For the purpose of transparency and public reporting, Dunwoody Village wishes to clarify the following facts that are portrayed differently by the Department of Public Welfare in this violation report. This incident occurred on Saturday, 11/19/10 at approximately 11am. Staff person "A" did not report an "allegation of abuse towards resident #1." Staff person "A," reported that she had witnessed something that she felt she should report to her supervisor. Following facility protocols, the supervisor immediately began an internal investigation and notified via telephone the Personal Care Administrator (PCA) and the Director of Nursing (DON). With the facts gathered at this</p>	<p>Steps have been taken to correct violation; full compliance is not verifiable <i>3/6/12</i> Date <i>LMC</i> Initials (DPW)</p>

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

Page 2 of 6 *cont'd part 2*

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PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <i>Mary McGoldrick RN PC Administrator</i>			
SIGNATURE OF LEGAL ENTITY <i>Mary McGoldrick</i>	DATE 1-19-12	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>	DATE 3/6/12

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42b A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.	<p>On November 19, 2011, Volunteer/Ombudsman C took Resident #1 for a walk about 10:00 a.m. The resident has dementia, lives in the home's secured dementia care unit (SDCU), requires 24-hour supervision, and has significant memory impairment resulting in an inability to discern time or place. The resident and volunteer/ombudsman were observed by staff holding hands as they returned to the resident's room about 11:00 a.m. and close the door.</p> <p>At about 11:20 a.m., Staff Person A noticed Volunteer/Ombudsman C open the door to the room, look up and down the hallway, and reclose the door. Staff Person A waited several minutes, then entered the resident's room. The staff person reports that the volunteer/ombudsman was standing next to the resident's bed and appeared startled by the staff person's appearance. The volunteer/ombudsman then jumped a few feet to the doorway placing himself between the resident and the staff person.</p> <p>Resident #1 then approached Staff Person A, who observed that the resident's shirt was untucked, pants were pulled down in the back</p>	<i>immediately</i>	<p>Violation, 42b. Dunwoody Village (as your report reads, the "Home") asserts that there are several inaccuracies with the facts as portrayed by the Department of Public Welfare (as your report reads, the "Department") Regional Licensing representatives. The Home also affirms that Resident #1 was not harmed in any manner unless you consider "playing footsie", "holding hands," or allowing a demented person to "play with your hair" or "accepting a kiss" from a demented person abuse and exploitation. The Home also asserts that it does not tolerate abuse of our residents in any manner, by any person!</p> <p>For the purpose of transparency and public reporting, the Home wishes to clarify the following facts that are portrayed differently by the Department of Public Welfare in this violation report. Both Resident #1 and Volunteer/Ombudsman "C" are both [redacted] years old. Resident #1 is demented and Volunteer/Ombudsman "C" may very well be forgetful and confused due to this age. On the date of this incident, November 19, 2011, Volunteer/Ombudsman "C" did not sign into the Home as a volunteer. Therefore, his actions on this date were that of a friend or companion visiting with this Resident. Although Resident #1 has dementia and cannot "discern time or place", [redacted] is a human being with feelings and emotions.</p> <p>Volunteer/Ombudsman "C" has a significant history with Resident #1, approximately five plus years. Resident's #1's daughter and Power of Attorney asked Volunteer/Ombudsman "C" to spend time with her [redacted] and was aware of their relationship. During a</p>	<p>Steps have been taken to correct violation; full compliance is not verifiable</p> <p><i>[Signature]</i> Date Initials (DPW) <i>MAC</i></p>

Jan 19 2012 6:46PM

MARY MCGOLDRICK

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

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42b	<p>approximately 6 inches, and adult brief was pulled down several inches on one side. Volunteer/Ombudsman C then abruptly left the room, and the resident followed calling out "My [redacted] my [redacted]."</p> <p>Staff later observed that Resident #1's pants were on backwards. Staff Person A had dressed the resident properly earlier in the day. Resident 1 needs physical assistance and verbal cueing to dress and cannot accomplish this task independently.</p> <p>During one investigative interview, Volunteer/Ombudsman C denied any recollection of the events of November 19, 2011, denied hearing the resident call after him in the hallway, and denied ever hearing Resident #1 refer to him as [redacted].</p> <p>During a second interview, Volunteer/Ombudsman C at first denied any recollection of November 19, 2011, but later offered that he had seen Staff Person A sitting outside the resident's room and remembered her entering the room. He also admitted that</p>		<p>facility interview, the daughter stated that they had a "healthy relationship" and that she was happy for her [redacted]. During this period, Volunteer/Ombudsman "C" would visit with Resident #1 on a daily basis to provide companionship as well as escort Resident #1 to various events throughout the community. The Home and its staff were acutely aware of this companionship and Resident #1's likes, dislikes and preferences.</p> <p>On November 19, 2011, at approximately 11:20 am, Staff person "A," felt that she had witnessed something that she should report to her supervisor and she did. Upon the facility's investigation, interviews with staff and with the FOA, we affirm that the following statements are true. Per the daughter of Resident #1, [redacted] has a life-long history of hearing noises and wanting to know what or where they were coming from. Per the staff, Resident #1 hears noises outside [redacted] room, in the hallway, and has asked the staff to look into the hallway. During an interview with Volunteer/Ombudsman "C", he has stated the same.</p> <p>Volunteer/Ombudsman "C" is an [redacted]-year old man with eccentric behaviors and nuances and the Home's staff is also aware of this. At his age, he very well may have been startled when Staff person "A" entered the room. The description from Staff person "A" of the Volunteer/Ombudsman "C" "jumping" is a perception.</p> <p>Resident #1 has a history of un-tucking [redacted] shirt and pulling [redacted] pants down slightly. This is confirmed by staff persons observing this behavior over a period of years. For the daughter, she has also observed Resident #1 un-tucking [redacted] shirt and slightly pulling down [redacted] pants for comfort.</p>	

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

Page 5 of 6 **PART 3**

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42b	<p>Resident #1 refers to him as [REDACTED]. Volunteer/Ombudsman C also admitted to playing "footsie" with the resident while sitting on the couch, that the resident "plays with his hair," that he accepts kisses from the resident on his mouth and cheek, and that he holds [REDACTED] hand while walking.</p> <p>Volunteer/Ombudsman C was vague about why he was at the resident's bedside with [REDACTED]. He first stated that he was checking the resident's clothing, next avoiding the question, and finally stating that he did not know why. He indicated that the resident frequently pulls [REDACTED] down pants a few inches and untucks [REDACTED] shirt. Multiple staff and family interviews indicate that the resident insists on keeping [REDACTED] shirt tucked in at all times.</p> <p>Interviews with staff at the home indicate that Volunteer/Ombudsman C works nearly exclusively with Resident #1 to the exclusion of all other residents at the home. He reportedly visits daily, often spending a minimum of 30 minutes in the resident's room with [REDACTED] with the door closed.</p>		<p>Resident #1 wears plain pants with an elastic waistband. It is very difficult to distinguish if the pants are on properly. The Regional licensing official's description on this report is inaccurate and portrays a negative connotation which is misleading to the reader. Specifically, this report reads that "Resident #1 needs physical assistance and verbal cueing to dress and cannot accomplish this task independently." Resident #1 is "able" to dress [REDACTED] without cueing and is able to go to the bathroom by [REDACTED] without assistance. However, because of our staffing levels and commitment to our residents, the staff routinely assists Resident #1 with [REDACTED] ADL needs. The Home reasonably believes that Resident #1 went to the bathroom alone on this date between [REDACTED] am and the time that Staff person "A" noticed [REDACTED] pants on backwards. We can also rationally conclude that the resident undressed and dressed [REDACTED] resulting in [REDACTED] pants being put on backwards.</p> <p>DPW officials interviewed Volunteer/Ombudsman "C" in a McDonald's and he did not comprehend that these officials were accusing him of abuse and he did not have a family member or an attorney present. The Home makes this statement because these same two DPW officials scolded Staff Person "B," the Home's Administrator for not conducting a rape kit on Resident #1 and for not preserving the "crime scene." Per the Home's interviews with Volunteer/Ombudsman "C" and his daughter, he had no recollection that he was being accused of abuse nor did he believe that he did anything wrong. During Volunteer/Ombudsman "C"'s interview with the COSA agent, Volunteer/Ombudsman "C's" daughter was present and the interview occurred in his home and</p>	

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DUNWOODY VILLAGE, 3500 WEST CHESTER PIKE NEWTOWN SQUARE, PA 19073

CURRENT LICENSE NUMBER
145250

INSPECTION DATES (Include all dates of the inspection)
1/29/2011

REGIONAL REPRESENTATIVE
Christine McHale, Lori Knockstead

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
Mary McGoldrick

DATE
1-19-12

REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION
[Signature]

DATE
3/6/12

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	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
42b	Volunteer/Ombudsman C is a volunteer staff person at the home and a volunteer ombudsman with the county ombudsman program. With consideration to this status, and the cognitive incapacity of the resident, the volunteer/ombudsman's acceptance and encouragement of the admitted level of intimacy between the two constitutes sexual abuse and exploitation.		<p>in private as a professional courtesy. During the interview with DPW, Volunteer/Ombudsman "C" was by himself and subjected to interrogation in a public setting, in this man's neighborhood. Going forward as part of our plan of correction, the Home will advise all persons being interviewed by any DPW agent to have an attorney present for the interview.</p> <p>During the facility's investigation, we learned that volunteers from the county Ombudsman's office do not receive "abuse" training. As part of our plan of correction, all Dunwoody volunteers will receive abuse training and acceptable behaviors training prior to starting their volunteer program.</p> <p>When the facility questioned Volunteer/Ombudsman "C" about why he accepted kisses and played "footsie", he stated that the Resident #1 initiated these actions. He also stated that he did not believe he was doing anything wrong. Proper training from the Home or County may have resulted in preventing this unfortunate situation. The facility was unaware of Resident #1 playing "footsie", playing with his "hair" and Volunteer/Ombudsman "C" "accepting kisses" from the resident. As part of our plan of correction, we will educate all volunteers on acceptable and unacceptable behaviors while working with our resident's.</p> <p>The facility disagrees with the "Department's" statement that "multiple staff and family interviews indicated that the resident insists on keeping [redacted] shirt tucked in at all times." The resident has been observed on numerous occasions un-tucking [redacted] shirt. The FOIA/daughter confirms this behavior as well from her visits.</p>	

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

Page 6 of 6 **PART 5**

NAME AND ADDRESS OF PERSONAL CARE HOME DUNWOODY VILLAGE, 3500 WEST CHESTER PIKE NEWTOWN SQUARE, PA 19073		CURRENT LICENSE NUMBER 145250	
INSPECTION DATES (include all dates of the inspection) 11/29/2011		REGIONAL REPRESENTATIVE Christine McHale, Lori Knockstead	
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>Mary McGoldrick</i>	DATE 1-19-12	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>[Signature]</i>	DATE 3/6/12

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	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
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VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

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