



**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE**

11 Stanwix Street  
Room 230  
Pittsburgh, Pennsylvania 15222

**ADULT RESIDENTIAL LICENSING**

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Mailing Date: APR 12 2012

Mr. Thomas Allhouse, Board President  
Dubois Continuum of Care Community, Inc.  
Dubois Village  
282 South Eighth Street  
Dubois, Pennsylvania 15801

Dear Mr. Allhouse:

As a result of the Department of Public Welfare's licensing inspection on February 3, 2012, 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 cursive script that reads "Maria Stepanovich".

Maria Stepanovich  
Regional Licensing Administrator

Enclosure(s)

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

NAME AND ADDRESS OF PERSONAL CARE HOME DUBOIS VILLAGE, 282 SOUTH EIGHTH STREET DUBOIS, PA 15801		CURRENT LICENSE NUMBER 316060	
INSPECTION DATES (Include all dates of the inspection) 02/03/2012		REGIONAL REPRESENTATIVE Brenda McAfee	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <p style="text-align: center;">Tammy L. HORNER, Administrator</p>			
SIGNATURE OF LEGAL ENTITY  <i>Tammy L. Horner</i>	DATE  4/9/12	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION  <i>Maia Stepanovich (MS)</i>	DATE  4/10/12

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
23a A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.	<p>On 1/27/12, resident #1 was observed eating dinner with a comb, instead of utensils, while staff persons A and B stood by watching. Resident #1's assessment, dated 12/15/11, and support plan, dated 12/16/11, indicate staff will provide the following regarding eating:</p> <ul style="list-style-type: none"> <li>• Some physical assistance as needed</li> <li>• Prompting and cueing for the resident to continue eating</li> <li>• Pre-cut foods</li> </ul> <p>This resident's dinner consisted of a whole piece of fish (not cut) on a bun. There were no utensils, beverage, vegetables or dessert on the dinner tray.</p> <p>Resident #1 has a diagnosis of dementia and resides in a secured dementia care unit. In addition, this resident's assessment indicates the resident needs total physical assistance with personal hygiene.</p> <p>Resident #1 did not receive assistance eating as indicated on the assessment and support plan.</p>	4/9/12	<p>Upon notification of incident staff persons A &amp; B were placed on immediate suspension for duration of investigation. Per staff conversations, there appears to have been no discernible negative change in behaviors of Resident #1. A review of the concerns log by Administration indicates no other issues which would indicate abuse or neglect. All staff was in-service on 4/10/12 on Resident care, ADL's and IADL's, importance and utilization of the RASP, documentation, prevention of abuse and neglect and their responsibilities. On 4/23/12 all staff was in-service on customer service. Conclusion of investigation resulted in termination of staff person A. Staff person B was provided one on one retraining on 4/28/12 prior to returning to duty which included: Dementia overview, utilization of RASP, meeting ADL and IADL needs, communication and caregiving techniques. The concerns log as well as incident and accident documentation will be reviewed by Administration on an ongoing basis to determine if there may be any opportunities for improvement in caregiving. Any areas for improvement will be addressed with the staff and included in the resident's RASP. A tracking log for this review will be maintained by Administration and findings reported at Quality Assurance meetings.</p>	

**RECEIVED**

05 10 2012

Date: 4/10/12  
 Initials: (BFW)  
 Staff have been instructed to correct violation; full compliance is not verifiable  
 4/10/12 MS

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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.	<p>On 1/27/12, resident #1 was observed eating dinner with a comb, instead of utensils, while staff persons A and B stood by watching. Resident #1's assessment, dated 12/15/11, and support plan, dated 12/16/11, indicate staff will provide the following regarding eating:</p> <ul style="list-style-type: none"> <li>Some physical assistance as needed</li> <li>Prompting and cueing for the resident to continue eating</li> <li>Pre-cut foods</li> </ul> <p>This resident's dinner consisted of a whole piece of fish (not cut) on a bun. There were no utensils, beverage, vegetables or dessert on the dinner tray.</p> <p>Resident #1 has a diagnosis of dementia and resides in a secured dementia care unit. In addition, this resident's assessment indicates the resident needs total physical assistance with personal hygiene.</p> <p>Resident #1 did not receive assistance eating as indicated on the assessment and support plan.</p>	4/9/12	<p>Staff members A &amp; B were placed on immediate suspension for suspected violation of resident rights and abuse pending outcome of investigation. Staff was in-service on 4/10/12 in resident reporting of abuse and also in-service on 4/10/12 on abuse prevention, resident rights, forms of abuse, characteristics of care, definitions of abuse and neglect, staff responsibility and mandatory reporters. At the conclusion of the investigation staff member A was terminated and staff member B was provided one-on-one retraining on resident rights, facility policy and procedure as well as PAW requirements for reporting of suspected neglect and/or abuse and abuse prevention prior to returning to duty. A follow up in-service on treating residents with respect and dignity will be scheduled in August 2012.</p>	<p>4/10/12 MS Initials (BFW)</p>

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