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 16 2012

Mr. Scott A. Farabaugh, Administrator
New Hope Assisted Living, Inc.
New Hope Assisted Living
300 Union Avenue
Avalon, Pennsylvania 15202

Dear Mr. Farabaugh:

As a result of the Department of Public Welfare's licensing inspection on March 21, 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,

Jill Pezzino
Regional Licensing Administrator

Enclosure(s)

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

NAME AND ADDRESS OF PERSONAL CARE HOME NEW HOPE ASSISTED LIVING 300 UNION AVENUE AVALON, PA 15202		CURRENT LICENSE NUMBER [illegible]
INSPECTION DATES (Include all dates of the inspection) 03/21/2012	REGIONAL REPRESENTATIVE Jason Williams, Carole Perry	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) SCOTT A. FARABAUGH ADMINISTRATOR		
SIGNATURE OF LEGAL ENTITY Scott A. Farabaugh	DATE 4/5/12	
REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION [signature] (JLP)	DATE 4-13-12	

REGULATION 55 Pa.Code §2600	VIOLATION	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 3/17/2012 at about 8:00 PM, Resident #1 had an episode of incontinence in his/her room. Staff person A asked staff person B for assistance in cleaning the resident's bathroom. Both staff persons entered the resident's room. After Staff person B finished cleaning the bathroom he/she saw the resident hanging up the wet pants instead of putting them to be laundered. While Staff person B was talking to the resident about the importance of cleaning the pants, Staff person A attempted to take the pants out of the closet while the resident wasn't looking. The resident then grabbed the arm of Staff person A to stop him/her from doing this. Staff person A grabbed the resident by the shoulders and pushed him/her back into the doorway of the closet and shouted "You mother f---er, don't ever touch me again, I'll kill you!" This incident was not reported to the Department until Tuesday 3/20/2012.	4/4/12	Violation is incorrect. The administrator was not informed, in writing, of the alleged incident until after the start of the 3:00-11:30 p.m. shift on Monday, March 19, 2012. Prior to that time, the information that was given to the administrator was erroneous and deceptive insofar as staff person A wrote an incident report that focused on the conduct of Resident #1versus the inappropriate conduct of herself (see exhibit 1). On the afternoon of 3/19/12, when caregiver B, who had observed the altercation, came to work and was questioned about the incident, she described, in a written incident report, what had actually happened between staff person A and Resident #1 (see exhibit 2). On the basis of caregiver B's incident report, the Administrator prepared the appropriate paperwork within 24 hours as specified by PA Code 2600, Regulatory Compliance Guide, "Suspected Resident Abuse Reporting and Investigation Requirements."	

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NAME AND ADDRESS OF PERSONAL CARE HOME	CURRENT LICENSE NUMBER
NEW HOPE ASSISTED LIVING, 300 UNION AVENUE AVALON, PA 15202	432,00

INSPECTION DATES (Include all dates of the inspection)	REGIONAL REPRESENTATIVE
03/21/2012	Jason Williams, Carole Perry

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	DATE	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION	DATE
[signature]	4/5/12	[signature]	4-13-12

REGULATION 55 Pa.Code §2600	VIOLATION		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
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 3/17/2012 at about 8:00 PM, Resident #1 had an episode of incontinence in his/her room. Staff person A asked staff person B for assistance in cleaning the resident's bathroom. Both staff persons entered the resident's room. After Staff person B finished cleaning the bathroom he/she saw the resident hanging up the wet pants instead of putting them to be laundered. While Staff person B was talking to the resident about the importance of cleaning the pants, Staff person A attempted to take the pants out of the closet while the resident wasn't looking. The resident then grabbed the arm of Staff person A to stop him/her from doing this. Staff person A grabbed the resident by the shoulders and pushed him/her back into the doorway of the closet and shouted "You mother f---er, don't ever touch me again, I'll kill you!" This incident was not reported to the local Area Agency on Aging until Tuesday 3/20/2012.	4/4/12	Violation is incorrect. The administrator was not informed, in writing, of the alleged incident until after the start of the 3:00-11:30 p.m. shift on Monday, March 19, 2012. Prior to that time, the information that was given to the administrator was erroneous and deceptive insofar as staff person A wrote an incident report that focused on the conduct of Resident #1versus the inappropriate conduct of herself (see exhibit 1). On the afternoon of 3/19/12, when caregiver B, who had observed the altercation, came to work and was questioned about the incident, she described, in a written incident report, what had actually happened between staff person A and Resident #1 (see exhibit 2). On the basis of caregiver B's incident report, the Administrator prepared the appropriate paperwork for the Area Agency on Aging within 24 hours.	

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VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME	CURRENT LICENSE NUMBER
NEW HOPE ASSISTED LIVING, 300 UNION AVENUE AVALON, PA 15202	432100

INSPECTION DATES (Include all dates of the inspection)	REGIONAL REPRESENTATIVE
03/21/2012	Jason Williams, Carole Perry

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	DATE	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION	DATE
Scott A. Farabaugh	4/5/12	JYP	4-13-12

REGULATION 55 Pa.Code §2600	VIOLATION		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
15b If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.	On 3/17/2012 at about 8:00 PM, Resident #1 had an episode of incontinence in his/her room. Staff person A asked staff person B for assistance in cleaning the resident's bathroom. Both staff persons entered the resident's room. After Staff person B finished cleaning the bathroom he/she saw the resident hanging up the wet pants instead of putting them to be laundered. While Staff person B was talking to the resident about the importance of cleaning the pants, Staff person A attempted to take the pants out of the closet while the resident wasn't looking. The resident then grabbed the arm of Staff person A to stop him/her from doing this. Staff person A grabbed the resident by the shoulders and pushed him/her back into the doorway of the closet and shouted "You mother f---er, don't ever touch me again, I'll kill you!" The home did not suspend Staff person A until 3/20/2012. Staff interviews indicate that staff person A was present in the home on 3/18/2012 unsupervised.	4/4/12	Violation is incorrect. The administrator was not informed, in writing, of the alleged incident until after the start of the 3:00-11:30 p.m. shift on Monday, 3/19/12. Prior to that time, the information that was given to the administrator was erroneous and deceptive insofar as staff person A wrote an incident report that focused on the conduct of Resident #1versus the inappropriate conduct of herself (see exhibit 1). On the basis of caregiver A's incident report, the Administrator had no reason to supervise caregiver A on 3/18/12.	

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[illegible]
PERSONAL CARE HOMES [illegible]

NAME AND ADDRESS OF PERSONAL CARE HOME NEW HOPE ASSISTED LIVING, 302 UNION AVENUE, AVALON, PA [illegible]		CURRENT LICENSE NUMBER [illegible]
INSPECTION DATES (Include all dates of the inspection) 3/21/2012	REGIONAL REPRESENTATIVE Jason Williams, Carole Perry	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on LAST PAGE only unless multiple representatives produce the plan)		

SIGNATURE OF LEGAL ENTITY	DATE	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION	DATE
[signature]	4/5/12	Withdrawn JGP 4-13-12	

REGULATION 55 Pa.Code §2600	VIOLATION	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
15d The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.	On 3/17/2012 at about 8:00 PM, Resident #1 had an episode of incontinence in his/her room. Staff person A asked staff person B for assistance in cleaning the resident's bathroom. Both staff persons entered the resident's room. After Staff person B finished cleaning the bathroom he/she saw the resident hanging up the wet pants instead of putting them to be laundered. While Staff person B was talking to the resident about the importance of cleaning the pants, Staff person A attempted to take the pants out of the closet while the resident wasn't looking. The resident then grabbed the arm of Staff person A to stop him/her from doing this. Staff person A grabbed the resident by the shoulders and pushed him/her back into the doorway of the closet and shouted "You mother f---er, don't ever touch me again, I'll kill you!" The resident's designated person was not notified of this incident until Wednesday 3/21/2012.	4/4/12	Violation is incorrect. On the basis of the time-line described on page 1, [redacted] Director of Resident Care Services, called the designated person on Monday, 3/19/12 at approximately 4:00 p.m. and left a detailed message on the answering machine regarding the incident, re-questing that she return the call. When the designated person arrived at New Hope on 3/21/12, for her regular visit with her [redacted] and administrative personnel asked her if she had received a voicemail, she replied that she had not checked her answering machine within the past few days. At that time she was informed of the incident. Subsequent to that discussion the designated person went to her [redacted] room to visit. At that time she spoke with the DPW inspector who was in the process of interviewing Resident #1 about the incident. When asked if she had been con-tacted regarding the incident she stated that she did not know anything about it until she arrived at New Hope.	

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

NAME AND ADDRESS OF PERSONAL CARE HOME	CURRENT LICENSE NUMBER
NEW HOPE ASSISTED LIVING, 303 UNION AVENUE AVALON, PA 15202	[illegible]

INSPECTION DATES (include all dates of the inspection)	REGIONAL REPRESENTATIVE
03/21/2012	Jason Williams, Carole Perry

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	DATE	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION	DATE
Scott A. Fairbaugh [signature]	4/5/12	[initials]	4-13-12

REGULATION 55 Pa.Code §2600	VIOLATION		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 A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.	On 3/17/2012 at about 8:00 PM, Resident #1 had an episode of incontinence in his/her room. Staff person A asked staff person B for assistance in cleaning the resident's bathroom. Both staff persons entered the resident's room. After Staff person B finished cleaning the bathroom he/she saw the resident hanging up the wet pants instead of putting them to be laundered. While Staff person B was talking to the resident about the importance of cleaning the pants, Staff person A attempted to take the pants out of the closet while the resident wasn't looking. The resident then grabbed the arm of Staff person A to stop him/her from doing this. Staff person A grabbed the resident by the shoulders and pushed him/her back into the doorway of the closet and shouted "You mother f---er, don't ever touch me again, I'll kill you!" Repeated Violations: 12/13/2011	4/4/12	The purpose of this regulation is to ensure that Residents are not neglected, intimidated, physically abused, mistreated, subjected to corporal punishment or disciplined in any way. On 3/20/12 a registered letter (Exhibit 3) was sent to staff person A informing her that she was suspended until an investigation could be conducted. Upon receipt of the formal Violation Report indicting that the altercation constituted abuse, she was sent a second certified letter of termination on 3/30/12 (Exhibit 4). New Hope makes every effort to ensure that Resident Rights is an ongoing training and education topic for all staff persons. In fact, Staff person A, 2/23/12. To date, for the 2012 training year, 34 individuals have completed this training module. In addition, a separate inservice training on "reportable incidents" was conducted on 3/22/12 and was attended by 24 individuals representing 3 shifts of the direct care staff (Exhibit 5).	Steps have been taken to correct violation; full compliance is not verifiable 4/13/12 [initials] Date Initials (DPW)

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NAME AND ADDRESS OF PERSONAL CARE HOME NEW HOPE ASSISTED LIVING, 300 UNION AVENUE AVALON, PA 15202	CURRENT LICENSE NUMBER 432130
INSPECTION DATES (Include all dates of the inspection) 03/21/2012	REGIONAL REPRESENTATIVE Jason Williams, Carole Perry

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	DATE	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION	DATE
Scott A. Fairbaugh	4/5/12	CJP	4-13-12

REGULATION 55 Pa.Code §2600	VIOLATION		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
227d Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services.	Resident #1 receives wound care from Celtic Home Care one to two times per week. This care is not included in the most recent Resident-Assessment-Support-Plan, dated 2/20/2012. RECEIVED APR 5 [illegible]	4/4/12	The purpose of this regulation is to ensure that support plans accurately reflect the care needs of each Resident. We have fixed the immediate problem by amending Resident #1's RASP to include Home Care services (see exhibit 6). In order to ensure ongoing compliance, on 4/3/12 the nurse who completes the RASP was re-oriented on New Hope's Policies and Procedures related the inclusion of medical care services, including home health services, in the appropriate section on the state required forms. 5-12-12 the nurse who completes the RASP will review all resident's assessments and support plans to ensure they are completed in their entirety including any services received from an outside agency such as Celtic Home Care. 4-13-12 CJP	Steps have been taken to correct violation; full compliance is not verifiable 4/13/12 CJP Date Initials (DPW)

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