



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

Sent via email to: [REDACTED]  
**MAILING DATE: December 20, 2012**

Mr. Ray C. Miller, Jr., Owner  
Berks Leisure Living, Inc.  
Berks Leisure Living  
1399 Fairview Drive  
Leesport, Pennsylvania 19533

Dear Mr. Miller:

As a result of the Department of Public Welfare's (Department) licensing inspection on December 5, 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 Human Services Licensing so that compliance can be verified.

Sincerely,

*Michele Moskalczyk*  
Michele Moskalczyk  
Regional Licensing Administrator

Enclosure  
Violation Report



Violation Report: 20569 - 12/05/2012 - Hummel, Jesse  
 PCH Name: BERKS LEISURE LIVING

**1. REGULATION 55 Pa.Code §2600**

2600.202 - The following procedures are prohibited:

- (1) Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited.
- (2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
- (3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
- (4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited.
- (5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited.
- (6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

**2a. DESCRIPTION OF VIOLATION**

Department Representatives determined through resident and staff interviews that on 11/22/12 at 10:00am staff person A noticed resident #1 walking toward the front door of the facility. Staff person A stood in the doorway blocking resident #1 from exiting the facility and stated to resident #1, "It is not a good idea to leave the facility at this time."

It was also determined that on 11/25/12 staff person A noticed resident #1 putting the resident's coat on. The resident made another attempt to leave the facility, however staff person A grabbed the arm of resident #1 again not permitting the resident from leaving the facility. Afterwards staff person A once again stood in the doorway blocking the resident from exiting the facility.

Physically blocking a doorway to prevent resident egress is considered a manual restraint and is prohibited.

**3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)**

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

*See Attached*

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Ray Calvin Miller Jr.*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Ray Calvin Miller Jr.* Date *12-14-12*

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of <i>12/18/12</i> (Date)	Plan of correction implementation status as of <i>12/18/12</i> (Date)
The above plan of correction was approved by <i>[Signature]</i> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

202

### Immediate Corrective Action Taken:

Partial Minutes from Staff Meeting Dec. 11, 2012:

As part of our staff meeting held at 1:30 PM and 9 PM, [REDACTED] spoke about the incident with [REDACTED]. The State Department was in to investigate the incident. They interviewed the staff that were involved and also the resident and [REDACTED] family. We are not to restrain a resident that wants to leave the building. If they insist on leaving, call 911 and the family immediately. You may continue to keep an eye on the resident only. It is part of Resident's Rights; manual restraints are prohibited. This includes blocking a doorway to prevent their departure. Also any physical contact such as holding their hands to prevent movement and holding down their shoulders to prevent them from standing is not allowed. The actual phrasing from the RCG book was read to the staff. When speaking to a resident, always speak with respect, sometimes firmness is appropriate.

Attending the meeting were 12 Out of 20 Personal Care Aids. The minutes from the staff meeting are to be given out to the entire staff with their paychecks.

### Future Action to Prevent Reoccurrence:

Although staff receives literature on Residents Rights in their introductory package, we are including further elaboration on the prohibition from any form of Restraints. This will be given out to all current staff to add to their employee handbook and also permanently included in the handbook.

Future Staff In-service Training will include a session with a representative from the Office of Aging to review Resident's Rights with emphasis on the prohibition of any restraints.

### Responsible Parties to Ensure Compliance:

[REDACTED] - Medical Manager

[REDACTED] - Administrative Assistant

M  
12/18/12