



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Mailing Date: February 25, 2013

Sent via email to: [REDACTED]

Ms. Jean Brady, President
Evergreen Elder Care, Inc.
The Villa St. Elizabeth
1201 Museum Road
Reading, Pennsylvania 19611

Dear Ms. Brady:

As a result of the Department of Public Welfare's (Department) licensing inspection on December 27, 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.

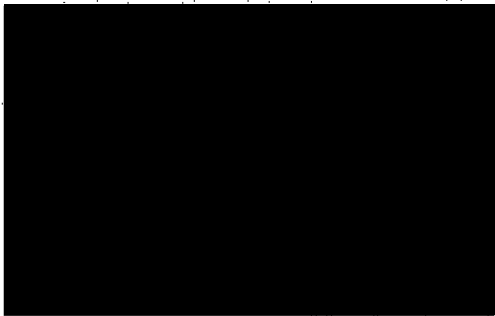
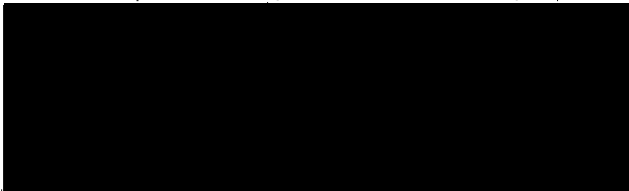
Sincerely,

A handwritten signature in black ink that reads "Michele Moskalczyk".

Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Violation Report

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

PCH Name: THE VILLA ST. ELIZABETH		License Number: 205760
Address: 1201 MUSEUM ROAD, READING, PA 19611		County: Berks
Administrator: Jean Bready		Region: NORTH
Legal Entity Name: EVERGREEN ELDER CARE INC		
Legal Entity Address: 1201 MUSEUM ROAD, READING, PA 19611		
Certificate(s) of Occupancy		
C-1 04/20/1992 L&I		
Staffing Hours		
Resident Support: 0	Total Daily Staff: 79	Working Staff: 59
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Complaint		
On-Site Inspections Dates and Department Representatives On-Site 12/27/2012: Novak, Ryan; Hummel, Jesse		
Off-Site Inspection Dates and Inspectors, if Applicable		
Other Details		
Partial or Full Triggers:	Random Indicators:	
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 92	Number of Residents who:	
Number of Residents Served: 79		
Secured Dementia Care Unit in Home: No		
Area:		
Secured Dementia Unit Capacity, if Applicable:		
		

Violation Report: 20576 - 12/27/2012 - Novak, Ryan

PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.16(c) - 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 section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 12/24/12 and 12/25/12 Resident #1 did not receive the prescribed Zioptan .0015% eye drops at bedtime. The home did not submit an incident report to the Department of the medication error.

On 12/16/12 Resident #2 did not receive the prescribed Aspirin, Clopidogrel, Digoxin, Ferrous Sulfate, Ferosemide, Levothyroxine, Metoprolol, Oxybutynin, Pontoprozole, Poly Glycol Powder, Ramipril, Thermis-M tablet, Vitamin B-12, Alphogan P drops. The home did not submit an incident report to the Department of the medication errors.

Cited Regulation 55 Pa.Code } 2600.16(c) -

"The home shall report the incident or condition to the Department's personal care home office . . ."

On both Christmas Eve (12-24-2012) and Christmas Day (12-25-2012), Resident #1 left the facility in the afternoon to visit family and returned late after 9PM in both cases. Since the only 8PM medication for this resident were the eyedrops, the med-tech initially noted the MAR with an OOF - out of facility - and intended to follow-up with the resident upon return. Instead, upon the return of resident each night, failed to notify the staff of return. The med-tech on duty each night failed to follow up to see when and/or if had returned. Resultantly, the med-tech also failed to document the OOF without medication given to the PCP or the DPW. The 12-16-2012 incident paralleled the above occurrence where Resident #2 was also out of the facility. In this case, the med-tech properly documented the incident in the MAR and sent notification to the PCP. Unfortunately, the incident report to the DPW was not sent.

The Villa staff is understands the importance of this regulation and is committed to insuring the proper medication administration to its residents. The regulation was violated by med-techs that had been thoroughly trained by our certified trainer, and re-covered in proper procedures for medication administration exception reporting three times. The failure to follow instructions and company procedures on the part of these med-techs caused these violations.

To insure the immediate correction of this violation, the Administrator covered all med-techs again on the proper procedure to follow relating to medication administration exceptions, including out-of-facility situations. These procedures include the proper notification of the exception to the Medication Manager, Administrator, the PCP, the resident's designated person and the DPW. Additionally, the med-techs directly involved with these occurrences were issued Employee Incident Report, requiring their immediate attention to avoid future errors. To prevent future violations of this type, all med-techs have been instructed to report any medication exceptions immediately to the designated manager on duty, who will assist the med-techs in their adherence to the proper reporting procedures. The MAR records will continue to be audited and signed off after each shift by the shift supervisors. The Med manager will daily review the MAR records to insure accuracy and compliance.

The Administrator will formally document her weekly review of all MAR records, as well as med cart reviews on an on-going basis to responsibly underscore the facility's commitment to the proper administration and documentation of the residents' medication.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)



Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

DENISE KASABA, ADMIN

Date 1-17-2013

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

The above plan of correction is approved as of

2/22/13
(Date)

Plan of correction implementation status as of

2/22/13
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by

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(Initials)

Violation Report: 20576 - 12/27/2012 - Novak, Ryan

PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION

Direct care staff member A reported that the MAR's for Resident #3's Novolin Insulin were not initialed as administered immediately on the medication administration record. Direct Care staff member reports the Medication administration record was not available.

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.

Cited Regulation 55 Pa.Code } 2600.187(b) -

"The information in }2600.187(a)(13) and (14) shall be recorded at the time the medication is administered."

The Staff Member A noted in this violation is the same med-tech responsible for the 12-24-12 and 12-25-12 incidents detailed on pages 2 and 5 of this report. The same staff member A caused the violation noted on Page 4, as well. The Villa staff and management realize the importance of properly recording the provisioning of medication at the time it is administered. All the MAR records are available to the med-tech staff at all times in the facility. The claim by staff member A that the MAR record was not available has no truth to it. Instead, this regulation was violated by this staff member's flagrant failure to follow the established procedures of the company regarding medication administration. Staff member A failed to take her MAR record with her when performing her blood sugar testing and insulin administration. Since she had not collected the MAR record from the Med Room, she violated procedures by trying to perform her duties without the records with her. Resultantly, she failed to record the entry because she did not have the MAR record with her insulin basket. As detailed on Page 2, this staff member A has been thoroughly trained on the proper procedures initially in her Diabetic training and in follow-up training sessions conducted by the Administrator.

- To insure the immediate correction of this violation, the Administrator covered all med-techs again on the proper procedure to follow relating to medication administration, including the immediate recording into the MAR records. These procedures also include the proper notification of any exceptions – such as refusals and out-of-facility incidents to the Medication Manager, Administrator, the PCP, the resident's designated person and the DPW. Staff member A was counseled by the Administrator about these breakdowns and that her performance and ability to follow direct instructions must improve immediately to safeguard her continued employment at the facility.
- To prevent future violations of this type, all med-techs have been instructed to report any medication exceptions immediately to the designated manager on duty, who will assist the med-techs in their adherence to the proper reporting procedures. The MAR records will continue to be audited and signed off after each shift by the shift supervisors. The Med manager will daily review the MAR records to insure accuracy and compliance.
- The Administrator will formally document her weekly review of all MAR records, as well as med cart reviews on an on-going basis to responsibly underscore the facility's commitment to the proper administration and documentation of the residents' medication.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
(Required on EVERY Page)



Printed Name and Title of Legal Entity Representative
(Required on EVERY Page)

DENISE KASABA, ADMIN

Date 1-17-2013

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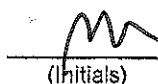
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2/22/13
(Date)

Plan of correction implementation status as of

2/22/13
(Date)

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(Initials)

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- Partially Implemented - Inadequate Progress
- Not Implemented

Violation Report: 20576 - 12/27/2012 - Novak, Ryan
 PCH Name: THE VILLA ST. ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.187(c) - If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

2a. DESCRIPTION OF VIOLATION

On 12/26/12 at 4:00 pm, Resident #3 refused to take have a blood sugar taken or insulin administered. The home did not notify the doctor of Resident #3's medication refusal.

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.

Cited Regulation 55 Pa.Code } 2600.187(c) -


"If a resident refuses to take a prescribed medication, the refusal shall be documented . . ."

On 12-26-12, staff member A failed to record the refusal to take medication by Resident #3. Again, the same staff member failed in her responsibility to properly perform her medication administration responsibilities. As of the date of this reply, staff member A has been terminated for continued failure to follow instructions and company procedures.

The Villa staff completely understands the importance of this regulation and is committed to insuring the proper medication administration to its residents. The regulation serves to protect the resident so that the PCP can correct any deficiencies with the resident's medical needs.

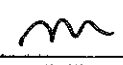
- To insure the immediate correction of this violation, the Administrator covered all med-techs again on the proper procedure to follow relating to medication administration exceptions, including refusal situations. These procedures include the proper notification of the exception to the Medication Manager, Administrator and the PCP. Additionally, the med-tech directly involved with this occurrence was issued an Employee Incident Report, requiring her immediate attention to avoid future errors. Unfortunately, she continued to make perform poorly and was terminated.
- To prevent future violations of this type, all med-techs have been instructed to report any medication exceptions immediately to the designated manager on duty, who will assist the med-techs in their adherence to the proper reporting procedures. The MAR records will continue to be audited and signed off after each shift by the shift supervisors. The Med manager will daily review the MAR records to insure accuracy and compliance.
- The Administrator will formally document her weekly review of all MAR records, as well as med cart reviews on an on-going basis to responsibly underscore the facility's commitment to the proper administration and documentation of the residents' medication.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DENISE KASABA, ADMIN	Date 1-17-2013
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The above plan of correction is approved as of <u>2/22/13</u> (Date)	Plan of correction implementation status as of <u>2/22/13</u> (Date)
The above plan of correction was approved by <u></u> (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

Violation Report: 20576 - 12/27/2012 - Novak, Ryan
 PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.188(b) - A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

2a. DESCRIPTION OF VIOLATION

On 12/24/12 and 12/25/12 Resident #1 did not receive the prescribed Zioptan .0015% eye drops at bedtime. The home did not notify the prescriber of the medication error.

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.

Cited Regulation 55 Pa.Code } 2600.188(b) -

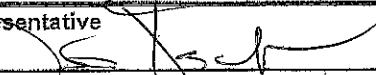
"A medication error shall be immediately reported to the resident's designated person and the prescriber."

As detailed on Page 2 earlier, the med-tech failed to notify the prescriber of the out-of-facility without medication of the 12-24-12 and 12-25-12 incidents. Similarly to the reporting to the DPW addressed on Page 2, the Villa staff understands and is committed to compliance to the reporting of exceptions to the medication administration to the residents. Our analysis and action plan of correction is parallel to the citing on Page 2 and therefore re-stated here.

On both Christmas Eve (12-24-2012) and Christmas Day (12-25-2012), Resident #1 left the facility in the afternoon to visit family and returned late after 9PM in both cases. Since the only 8PM medication for this resident were the eyedrops, the med-tech initially noted the MAR with an OOF - out of facility - and intended to follow-up with the resident upon return. Instead, upon the return of resident each night, failed to notify the staff of return. The med-tech on duty each night failed to follow up to see when and/or if had returned. Resultantly, the med-tech also failed to document the OOF without medication given to the PCP or the DPW.

- The Villa staff is understands the importance of this regulation and is committed to insuring the proper medication administration to its residents. The regulation was violated by a med-tech who had been thoroughly trained by our certified trainer, and re-covered in proper procedures for medication administration exception reporting three times. The failure to follow instructions and company procedures on the part of this med-tech caused this violation.
- To insure the immediate correction of this violation, the Administrator covered all med-techs again on the proper procedure to follow relating to medication administration exceptions, including out-of-facility situations. These procedures include the proper notification of the exception to the Medication Manager, Administrator, the PCP, the resident's designated person and the DPW. Additionally, the med-techs directly involved with these occurrences were issued Employee Incident Report, requiring their immediate attention to avoid future errors.
- To prevent future violations of this type, all med-techs have been instructed to report any medication exceptions immediately to the designated manager on duty, who will assist the med-techs in their adherence to the proper reporting procedures. The MAR records will continue to be audited and signed off after each shift by the shift supervisors. The Med manager will daily review the MAR records to insure accuracy and compliance. The Administrator will formally document her weekly review of all MAR records, as well as med cart reviews on an on-going basis to responsibly underscore the facility's commitment to the proper administration and documentation of the residents' medication.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
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Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) DENISE KASABA, ADMIN Date 1-17-2013

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