COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **GRACE PARK LTD.**
LEGAL ENTITY

To operate **GRACE PARK**
NAME OF FACILITY OR AGENCY

Located at **1170 WEST MAIN STREET, STROUDSBURG, PA 18360**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

ADDRESS OF SATELLITE SITE | ADDRESS OF SATELLITE SITE

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **82** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 22**

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 17, 2013** until **June 17, 2014**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **207360**

Robert E. Robinson
ISSUING OFFICER

DIRECTOR

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

PW 628 – 01/11

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

JUN 1 7 2013

Mr. George R. Loudon, President
Grace Park, LTD
1222 Lower Cherry Valley Road
Stroudsburg, Pennsylvania 18360

RE: Grace Park
1170 West Main Street
Stroudsburg, Pennsylvania 18360

Dear Mr. Loudon:

As a result of the Department of Public Welfare's (Department) licensing inspection on February 12, 2013, 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.

A regular license is being issued based on the enclosed Violation Report. Your license is enclosed.

Sincerely,

Ronald Melusky
Director

Enclosures
License
Violation Report

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

PCH Name: GRACE PARK	**License Number:** 207360
Address: 1170 WEST MAIN STREET, STROUDSBURG, PA 18360	**County:** Monroe
Administrator: Mary Jane Dugas	**Region:** NORTH

Legal Entity Name: GRACE PARK LTD

Legal Entity Address: 1222 LOWER CHERRY VALLEY ROAD, STROUDSBURG, PA 18360

Certificate(s) of Occupancy

I-1	I-1	
10/17/2005	09/15/2006	11/03/2011
Bor. of Stroudsburg	Bor. of Stroudsburg	Bor. of Stroudsburg

Staffing Hours

Resident Support: NA	**Total Daily Staff:** 76	**Waking Staff:** 57
Type of Inspection: Full	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

02/12/2013: Patton, Leslie; Hummel, Jesse

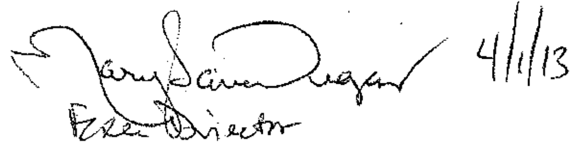
Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 82	**Number of Residents who:**
Number of Residents Served: 61	**Receive Supplemental Security Income:** 0
Secured Dementia Care Unit in Home: Yes	**Are 60 Years of Age or Older:** 61
Area: part of 2nd floor	**Have Mental Illness:** 0
Secured Dementia Unit Capacity, if Applicable: 22	**Have an Intellectual Disability:** 0
Number of Residents Served in Secured Dementia Care Unit, if applicable: 13	**Have a Mobility Need:** 15
Number of Current Hospice Residents: 4	**Have a Physical Disability:** 0
Number of Hospice Residents in past year: 4	



Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600
2600.96(b) - Staff persons shall know the location of the first aid kit.

2a. DESCRIPTION OF VIOLATION
Staff person #1 was asked to locate the first aid kit in the secured Dementia unit. Staff person #1 searched the cabinets in the medication room, uncertain of its location, and at one point mistook the plastic case containing a breathing shield as being the first aid kit. Staff person #1 had to be given subtle hints from staff person #2 in order to locate the first aid kit which was stored in a closet near the dining room in the secured Dementia unit.
When completing a medication audit with staff person C in the 1st floor medication room, staff person C was asked to locate the first aid kit. Staff person C also began to look in the cabinets in the medication room and had to be told by staff person B that the first aid kit was not located in the medication room. The staff person was able to indicate a first aid kit is present in the dining room and kitchen but did not know that the first aid kit located closest to the medication room, only yards away, was stored in the "grab bag" in the linen closet.

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 attachment A.

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative **(Required on EVERY Page)** [signature]

Printed Name and Title of Legal Entity Representative **(Required on EVERY Page)** MARY JANE DUGAS, Exec. Director — **Date** 4/1/2013

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

The above plan of correction is approved as of 4/17/13 (Date)

The above plan of correction was approved by M (Initials)

Plan of correction implementation status as of 4/17/13 (Date)

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

Mary Jane Dugan 4/1/13
Exec. Director

ATTACHMENT A

Attachment regarding violation number 2600.96 (b) – staff persons shall know the location of the first aid kit.

Due to the fact that this is an isolated issue and not a repeat violation, I would respectfully request an appeal regarding all or part of this cited violation.

The reason for the regulation is to that staff may receive or may access a first aid kit quickly in the event of an emergency.

The citation surrounding this "violation" leads one to believe that my staff is not familiar with the location of our first aid kits.

Staff person "#1" did not mistake a brand new CPR breathing shield as a first aid kit. This staff person is quite familiar with how to differentiate between a breathing shield and a first aid kit. She was trying to expose the inspector to this larger device (smaller shields are in the first aid kits) as also available to the staff should they need it in addition to our regular first aid kits. The report as written by BHSL does not reflect the atmosphere of the SCDU at the time of the line of questioning by the inspector. I would like to note that in the midst of questioning, this staff person whom has worked with me for over six years was greatly distracted by a resident hollering out so loudly that it caused a distraction where she thought the resident was in distress. The situation caused her to be greatly distracted, nervous, and rather flustered. Her instinct was to care for the resident. While I am confident and knowledgeable that our resident was well attended to I am also confident that this staff person (who actually helped to identify the original locations of our first aid kits) is exceptionally familiar with all of these locations.

In reference to "Staff person C"; this staff person did, in fact, cite specific locations of our first aid kits. She did not indicate to the inspector the kit located in the "grab bag" due to the fact that what the inspector is referring to as our "grab bag" is actually our disaster bag and while it does include a first aid kit we do not routinely break open the disaster bag to obtain the first aid kit when there is another located nearby as identified by "Staff person C".

The plan of correction:

As is customary in our community; orientation and on-going education does and will continue to occur as part of our training and will continue to include the locations and familiarity of the locations of all of the first aid kits. I will also continue to display the poster in the staff area which identifies all of the locations of our first aid kits. As of the date of this report I have attracted more attention to the poster through the use of color and have already personally reviewed the locations with "Staff person C" and "Staff person 1".

Again, I respectfully request that you consider my appeal of this violation since it is not a repeat violation and appears to be isolated.

MM 4/17/13

Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600
2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION
It is the home's policy that all narcotic medications be counted by two staff persons at the beginning and end of each shift and staff is to document the current number of narcotics on the narcotic count log. Resident #1 is prescribed Fentanyl patch 25mcg, of which there was a box opened and being used as well as a full unopened box containing 5 patches in the first floor medication cart. Staff person C stated the unopened box of patches is counted at the beginning and end of each shift, but staff is not documenting having counted the unopened box of patches per the home's policy.

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 attachment B.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative
(Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) MARY JANE DUGAS, Exec Director — **Date** 4/1/2013

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The above plan of correction was approved by MM (Initials)

Plan of correction implementation status as of 4/17/13 (Date)

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

Mary Jane Dugan Exec Director 4/1/13

ATTACHMENT B

Attachment regarding violation number 2600.185 (a) – The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

The importance of this regulation is to monitor the identifiers in the regulation with continuity and consistency to insure safe storage and medication accountability and management thereof. While there actually WAS a signature log page in place for the narcotics overall, there was no individual page accounting twice daily at shift change for the unopened container.

I believe the medication technicians felt that signing for the narcotic medications overall, in their entirety, on the main signature narcotic log (as maintained in addition to the individual forms) did suffice to account for the unopened medication. There was no pattern of this behavior; all medications are accounted for.

Plan of Correction:

To correct the matter as noted, a single page identifying the unopened medication and quantity were added to the narcotic count binder. The resident has since passed away and the medication is no longer present in the PCH. Future medications management of all unopened narcotic medicine will be maintained in the same manner as those that are opened and accounted for: by utilizing a narcotic count form. In an effort to prevent any further occurrence, the Clinical Care Management staff will oversee proper use of the forms with the medication technician staff.

- The administrator will monitor for ongoing compliance.

MM 4/17/13

Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

(1) Resident's name.
(2) Drug allergies.
(3) Name of medication.
(4) Strength.
(5) Dosage form.
(6) Dose.
(7) Route of administration.
(8) Frequency of administration.
(9) Administration times.
(10) Duration of therapy, if applicable.
(11) Special precautions, if applicable.
(12) Diagnosis or purpose for the medication, including pro re nata (PRN).
(13) Date and time of medication administration.
(14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION

Resident #2 is prescribed Apidra insulin with two different orders for administration based upon the resident's blood sugar reading before each meal and at bedtime. The staff did not sign or initial the resident's Medication Administration Record to indicate Insulin was administered on the following dates and times:
8:00am on 2/1/13, 2/6/13 and 2/8/13
5:00pm on 2/1/13, 2/2/13, 2/9/13, and 2/10/13
8:00pm on 2/1/13, 2/2/13, 2/5/13, and 2/8/13- 2/10/13

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 attachment C

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative [signature]
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative MARY JANE DUGAS, Exec Director
(Required on EVERY Page)

Date 4/1/13

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

The above plan of correction is approved as of 4/17/13 (Date)

The above plan of correction was approved by MM (Initials)

Plan of correction implementation status as of 4/17/13 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

ATTACHMENT C

Mary Jane Dugan
Exec Director 4/1/13

Attachment regarding violation number 2600.187 (a) – A medication record shall be kept to include the following for each resident for whom medication are administered: resident name, drug allergies, name of medication, strength, dosage form, dose, route of administration, frequency of administration, administration times, duration of therapy, special precautions, diagnosis or purpose of for the medication, Date and time of medication administration, and name and initial of the staff person administering the medication.

The importance of this regulation is to oversee the management of medication delivery.

The staff did not sign the Medication Administration Record to indicate insulin was administered.

The electronic Medication Administration Record (EMAR) as documented reflected an accuchek as a straight order.

The EMAR did therefore reflect a separate order for the insulin which was noted as a PRN or as needed medication due to the fact that the amount of insulin to be administered, if any at all, was based on an accuchek sliding scale as needed.

The EMAR system works in a fashion similar to that of a traffic stop light. If the indicator on the EMAR is green, all is good; if the indicator on the EMAR is yellow, there is caution to follow up on such as the results from administering a prn may need to be entered post administration etc,; if the indicator on an EMAR is red then there is an issue urgent in nature requiring immediate attention. The medication technicians refer to this as their "dashboard" system.

The medication technicians have acknowledged that they were administering the insulin according to the sliding scale as ordered however they failed to sign for the dosage on the dates noted.

Plan of Correction:

As of the date of our state inspection, 2/12/2013 our pharmacy has corrected the manner in which the accuchek and insulin orders are noted in the EMAR system.

The EMAR now prompts an accuchek reading entry and signature upon administering any insulin and the units self-administered.

All Clinical Care Managers and Medication Technicians will follow proper protocol and procedure when administering medications. The monitoring will include use of the "dashboard" to assist in identifying any outstanding issues in the midst of a medication pass. This will allow for extreme accuracy for the recording of signatures and prevent future violations.

M 4/17/13

Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600
2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
Resident #3 was admitted to the secured dementia unit on 11/16/12. The resident's medical evaluation dated 11/19/12 was not completed within 60 days prior to resident # 3's admission to the Secured Dementia Unit as required. The medical evaluation also does not indicate a diagnosis of Alzheimer's disease or Dementia and does not specify the need for the resident to be served within a Secured Dementia Care Unit.

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):			

Signature of Legal Entity Representative **(Required on EVERY Page)** [signature]

Printed Name and Title of Legal Entity Representative **(Required on EVERY Page)** MARY JANE DUGAS, Exec. Director — **Date** 4/1/13

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

The above plan of correction is approved as of 4/17/13 (Date)

The above plan of correction was approved by mm (Initials)

Plan of correction implementation status as of 4/17/13 (Date)

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

Mary Jane Ziegler
Exec Director 4/1/13

ATTACHMENT D

Attachment regarding violation 2600.231 (b) – A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's' disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Thank you for allowing me the opportunity to elaborate on this matter. I am respectfully requesting an appeal of this cited violation.

This resident **was not required** to reside in our Secure Care Dementia Unit (SCDU) however she did choose to do so.

The resident's screening was completed on October 8th, 2012.

She was observed to be a bit forgetful but had no other impairments or diagnoses.

She was originally admitted to our PCH on October 11, 2012.

The resident had a DME completed on October 22, 2012.

She had no diagnosis noted on that DME because there were no clinical findings at that time.

She seemed to wander because of the sheer size of our community. She began visiting residents in our SCDU. The smaller setting seemed to satisfy her socially and she did not wander around trying to find something to do or someone she knew to chat with. Overall she began to flourish when she spent time in the SCDU. As a matter of fact when she was interviewed by the inspector during our inspection she did indicate she moved there because it was a smaller place to live and she liked it.

She was not required to transfer to our SCDU but she and her family opted for The Garden House (our SCDU) and she did move there on 11/16/2012.

Her screening was also completed on that date and does reflect "wandering" as an indicator. "Wandering" is actually one of the "behaviors exhibited" on the form as provided by DPW and was/is an indicator of an "other dementia".

She did have a DME completed October 22nd, 2012 upon first admission to the home.

Because her admission to the SCDU was not a requirement but a choice made by the resident the initial DME did not indicate that the resident needed to be served in a SCDU, nor had she been clinically diagnosed with any dementia.

The DME was completed in accordance with a resident who does not REQUIRE a SCDU as was the case here.

In the event that BHSL is not willing to consider the appeal of this violation, we do understand the importance of the regulation and have already had the resident further evaluated by her physician and nurse practitioner and an updated DME is present on her chart in the home. This corrective action occurred on 2/19/2013 post inspection. It is always our goal to be 100% compliant. The Executive Director and Clinical Care Management staff will continue to oversee admissions and the paperwork thereof are completed with accuracy and in a timely fashion in accordance with our regulations.

See 2319

4/17/13

Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600

2600.231(g) - An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident.

(1) The individual shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to residence or 30 days after residence.

(2) If the medical evaluation shows that personal care services are needed, the requirements of this chapter apply.

(3) The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

Resident #3 was admitted to the secured dementia care unit on 11/16/12. The resident's preadmission screening dated 11/16/12 states the reason for the resident leaving current residence was due to wandering. The resident does not have a diagnosis of Alzheimer's disease or other Dementia as recorded on the resident's medical evaluation dated 11/19/12. Department Representatives interviewed resident #3 and determined that the resident was unaware that the resident was residing in a locked unit. The resident also did not comprehend the electronic key pad mechanism in order to exit the unit, which is required for a resident to reside on a secured unit without a diagnosis of Alzheimer's disease or Dementia.

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.

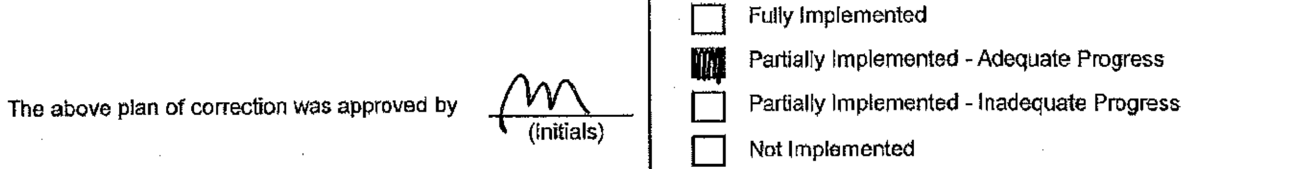
See attached E

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Mary Jane Dugas, Exec. Director **Date** 4/1/13

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



The above plan of correction is approved as of 4/17/13 (Date)

The above plan of correction was approved by M (initials)

Plan of correction implementation status as of 4/17/13 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Mary Jana Regar 4/1/13
Exec. Director

ATTACHMENT E

Attachment regarding Regulation 2600.231 (g) – An individual who does not have a primary diagnosis of Alzheimer's disease or other dementia may reside in the secured dementia care unit if desired by the resident. (1) The resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, withinn60 days prior to residence or 30 days after residence. (2) If the medical evaluation shows that personal care services are needed. The requirements of this chapter apply. (3) The individual shall have access to and be able to follow directions for the operation of the key pads or other lock-releasing devices to exit the secured dementia care unit.

The violation indicated reflects that the "Department Representatives interviewed resident #3 and determined that the "resident was unaware that she was residing in a locked unit."

Interestingly enough when the resident was interviewed by the inspector; the inspector advised the Executive Director that she told him she lived there because she liked the smaller environment- which was accurate. We do not refer to The Garden House as a "locked unit" although it is recognized as a SCDU. The residents who have apartments in this area are not restricted from the remainder of the building. There are a number of our residents who visit in other areas of our building and vice versa.

The resident who was previously referred to in 2600.231 (b) does have access to the key pads and has on occasion entered the code in and been able to voluntarily exit The Garden House into other areas of the personal care home. Since the resident was not able to perform this task under the watchful eye of the state inspector we have re-educated her on the practice of entering the code for the lock release mechanism. The alternative is to depress the handle for more than twenty seconds and the door will release automatically.

Plan of Correction:

Subsequently on a DME completed in February, the resident did have extensive testing completed with her physician and nurse practitioner and has an updated DME on file with a clinical diagnosis of dementia and her RASP was updated accordingly.

The Clinical Care Manager's and Executive Director will insure that all resident's admitted to the SCDU that DO NOT have a diagnosis of Alzheimer's disease or Dementia and are residing in the SCDU voluntarily; that they do have the appropriate education for ongoing use of the electronic key pad mechanism in order to exit the unit. In the event that a resident is residing in the SCDU and they are unable to manage the key pad mechanism without assistance we will have them further evaluated for any new clinical findings and update their RASP accordingly.

M 4/17/13

Violation Report: 20736 - 02/12/2013 - Patton, Leslie
PCH Name: GRACE PARK

1. REGULATION 55 Pa.Code §2600
2600.236 - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

2a. DESCRIPTION OF VIOLATION
Staff person D (hired 9/11/06) provides direct care services in the secured Dementia unit of the home. The staff person completed 2 of the 6 additional house of training required to be related to Dementia care and services during the 2012 training year.

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 F.

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative [signature]
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative MARYJANE [illegible] Exec. Director — **Date** 4/1/13
(Required on EVERY Page)

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

The above plan of correction is approved as of 4/17/13 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 4/17/13 (Date)

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

Mary Jane Dugan 4/1/13
Exec Director

ATTACHMENT F

Attachment regarding Regulation 2600.236 – Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in 2600.65 (relating to direct care staff person training and orientation.)

I am respectfully requesting an appeal of the citation for this "violation" in lieu of the fact that the employee did have many hours over and above the required training for dementia care and services.

According to the description of the violation; Staff person D (hired 9/11/06) provides direct care services in the SCDU of the home. The staff person completed 2 of the 6 additional hours of training required related to Dementia care and services during the 2012 training year.

The importance of this regulation is noted so that we continue on the cutting edge of great care for our elderly population.

The employee incurred the following training for the calendar year 2012 as referred to in this "violation":

Training	Hours
Hearing Disorders and Myths	1 hour
Diabetes Care and Insulin Management (actual 4 hour class) only counts for	2 hours
Falls, Accident Prevention and Reporting, Incident reports & reportable incidents	1 hour
Personal Care Services, Pre-admission screening, ADL's, DME, RASP, Resident rights, Resident handbook, resident agreement,	1 hour
Emergency Preparedness, Safe Management Techniques	1 hour
Resident Rights/OAPSA	1 hour
Fire Safety Training	1 hour
Oral Healthcare	1 hour
* Dementia Tips with ADL's	1 hour
Infection Control	1.5 hours
• Dementia/Alzheimer's geriatric series (DPW only recognizes 2 hours of this toward dementia)	5.25 hours
Medication Administration	1.5 hours
Sub-Total	**18.25 hours**

PLUS TRAINING COMPLETED 2/17/2013 as noted below (per recommendation of inspector to make up for dementia training "missed" for 2012.)

Training	Hours
Dementia Care effects of medication	1 hour
Dignity and Sexuality Issues with Dementia	.5 hour
Dementia Care and Hydration	.5 hour
Dementia Care Health Complications	.5 hour

(F. continued)

Mary Sanna Dugan 4/1/13
Exec Director

Dementia Care Aggressive Behaviors	1 hour
Dementia Care Sun downing	1 hour
Grand Total 2012 Training including "make-up" training	**22.5 hours**

The requirement is that the staff has an additional 6 hours of training related to dementia care AND SERVICES. The training provided pre-inspection is reflective of dementia care and "services".

People that have memory impairments also have other issues requiring the skills of a caregiver. I believe that even residents with dementia/Alzheimer's or other memory related impairments that may reside in a SCDU have hearing aids, oral health care needs, etc. and would benefit from any of the training this employee has attended. Thus the term "services" as noted in the regulation.

I believe this employee has had adequate training in dementia care and services to satisfy the training requirements as set forth in the regulation and again, respectfully request that this violation be rescinded.

Plan of Correction:

In the event that the BHSL will not allow service training and waive this citation the following plan of correction will be followed:

For all future training the Executive Director will insure that there is appropriate wording in the title of the training to indicate that it covers dementia and Alzheimer's resident care. All staff will have an additional 6 hours of training in addition to the 12 base hours required.

MM 4/17/13