



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: July 31, 2013

Mr. David Barnes, Authorized Agent
Watermark Operator, LLC
2020 Rudasill Road
Tucson, Arizona 85704

RE: Rose Tree Place
500 Sandy Bank Road
Media, Pennsylvania 19063

Dear Mr. Barnes:

As a result of the Department of Public Welfare's licensing inspection on May 21, 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 Adult Residential Licensing so that compliance can be verified.

Sincerely,

A handwritten signature in black ink that reads "Christine McHale" followed by a circular flourish or initial.

Christine McHale
Acting Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

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

PCH Name: ROSE TREE PLACE		License Number: 13281
Address: 600 SANDY BANK ROAD, MEDIA, PA 19063		County: Delaware
Administrator: Timothy Ballas		Region: SOUTHEAST
Legal Entity Name: WATERMARK OPERATOR LLC		
Legal Entity Address: 2020 WEST RUDASILL ROAD, TUCSON, AZ 85704		
Certificate(s) of Occupancy		
Staffing Hours		
Resident Support: 0	Total Daily Staff: 175	Working Staff: 131
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced
Reason(s) for Inspection(s) Incident		
On-Site Inspection Dates and Department Representatives On-Site 08/21/2013: Kazimer, Lauren; Sledge, Andrea		
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: 149 Number of Residents Served: 119 Secured Dementia Care Unit In Home: Yes Area: Secured Dementia Unit Capacity, if Applicable: 28 Number of Residents Served in Secured Dementia Care Unit, if applicable: 22 Number of Current Hospice Residents: 8 Number of Hospice Residents in past year: 23	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 117 Have Mental Illness: 2 Have an Intellectual Disability: 0 Have a Mobility Need: 56 Have a Physical Disability: 2	

Violation Report: 13281 - 06/21/2013 - Kazimor, Lauren
 PCH Name: ROSE TREE PLACE

1. REGULATION 65 Pa.Code §2600
 2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION
 Resident #1 had an unwitnessed fall in their bedroom around 4:15am on 6/9/13. Third shift staff members responded to the call pendant and assessed the resident. According to staff, the resident denied pain or hitting their head during the fall. Staff assisted resident #1 back into bed and left the room around 4:45am.

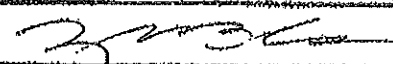
 Staff reported that they would check on the resident before they left at the end of their shift. Not all staff members on the next shift were made aware of resident #1's fall. Approximately six hours later, at 11:30am, resident #1's roommate made staff aware that the resident had not been seen all morning. Staff went into resident #1's room to find her unresponsive, with no pulse, and cold to the touch. Resident #1 was pronounced dead at 11:55am. Staff neglected to check on the resident after the unwitnessed fall when they stated they would.

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.

Please see attached

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)	Timothy Ballar	Date	6/7/13
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>6/11/13</u> (Date)	Plan of correction implementation status as of <u>6/11/13</u> (Date)
The above plan of correction was approved by <u>Orem</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

Regulation 2600.42(b)

A Resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Plan of correction

We request this violation be withdrawn. The Resident was never neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

According to the Regulatory Compliance Guide regulation 42b prohibits "Neglect of the Resident, which results in physical harm, pain or mental anguish". The Coroner report stated the resident's cause of death was Intracerebral hemorrhage due to or as a consequence of arteriosclerotic cardiovascular disease. Other significant conditions contributing to death: hyperlipidemia, gastroesophageal reflux disease. According to Dr. [REDACTED] the medical examiner, her death was not due to injury. It was classified as a natural death. (Attachment #1 and #2).

The Resident had no injury at the time of the fall. She indicated she did not hit her head, she moved freely about and denied that she was experiencing any pain. The resident was alert oriented and joking with the nurse when assessed her after the fall. She was not in any distress, all assessment findings were normal, and stated she was fine. As per her Assessment and RASP, the resident was alert and oriented and needed very minor assistance with ADL's, assistance only in or with showering. Resident often chose to eat breakfast in her room. The staff nurse did tell the resident's family he would check on the resident before he left at the end of his shift, expecting it would be primarily for emotional support. However as will happen in nursing, he was pulled into another emergency that morning before leaving, so he was unable to do this himself. However, he did the appropriate action of reporting the fall occurrence to the on-coming nursing supervisor and gave his post-fall assessment findings, where all findings were WNLs. The nursing supervisor who was working the next shift intended to check in as a follow up and would have checked on the resident during her shift. She was however called to the room by the aid at approximately 11:30am before she could do so.


When the off going Supervisor left the resident at approximately 4:45am, she (Resident) was capable of pushing her alarm pendant if she had any concerns. The day nurse was called to room at 11:30am. Post incident follow up on a resident with this level of acuity would be expected to be within the shift by the Nurse. In view that the aides would check in on their rounds and report issues, and that the nurse still had several hours remaining in her shift to document her full post fall assessment, we do not feel this warrants a finding of an act of neglect.

If the violation is not withdrawn the following is the plan of correction for the violation

Watermark Retirement Communities recently initiated an "Alert Charting" policy which indicates all residents will be assessed post incident at various intervals during the 72 hours following the incident. The documentation will be completed by Resident Care Director and/or Nursing Supervisors. Although it was normal practice to assess a resident for three days post fall this policy clearly defines the expectations.

To assure on-going compliance, all Caregivers receive a crossover meeting with supervisors at the start of their shift to be made aware of any incidents or pertinent information.

The Resident Care Director, will have oversight of alert charting and crossover meetings.

 6/7/13