



**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE:**

JUL 10 2013

Mr. Charles W. Hastings Jr., VP Juniper Partners LLC  
Cordia Commons at Meadville, LLC  
400 Broadacres Drive  
Bloomfield, New Jersey 07003

RE: Juniper Village at Meadville  
45 Chestnut Street  
Meadville, Pennsylvania 16335

Dear Mr. Hastings:

As a result of the Department of Public Welfare's (Department) licensing inspection on May 29, 2013 and May 30, 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.

Sincerely,

Maria Stepanovich  
Regional Licensing Administrator

Enclosure(s)

**VIOLATION REPORT**  
**PERSONAL CARE HOMES - 55 Pa. Code Chapter 2609**

PCH Name: JUNIPER VILLAGE AT MEADVILLE		License Number: 41019
Address: 455 CHESTNUT STREET, MEADVILLE, PA 16336		County: Crawford
Administrator: Jennifer Musone		Region: WEST
Legal Entity Name: CORDIA COMMONS AT MEADVILLE LLC		WEST REGION FIELD OFFICE Human Services Licensing
Legal Entity Address: 400 BROADACRES DRIVE, BLOOMFIELD, NJ 7003		
<b>Certificate(s) of Occupancy</b> C-2 LP 12/27/1994 Labor & Industry		
<b>Staffing Hours</b> Resident Support: N/A                      Total Daily Staff: 93                      Waking Staff: 70		
Type of Inspection: Partial                      BHA Docket Number: N/A                      Notice: Unannounced		
<b>Reason(s) for Inspection(s)</b> Incident		
<b>On-Site Inspections Dates and Department Representatives On-Site</b> 05/29/2013: Mazza, Larry 05/30/2013: Mazza, Larry; Perry, Carole		
<b>Off-Site Inspection Dates and Inspectors, If Applicable</b>		
<b>Other Details</b> Partial or Full Triggers: N/A                      Random Indicators: N/A		
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 90 Number of Residents Served: 72 Secured Dementia Care Unit In Home: No Area: Secured Dementia Unit Capacity, If Applicable: Number of Residents Served in Secured Dementia Care Unit, If applicable: Number of Current Hospice Residents: 2 Number of Hospice Residents in past year: 13	<b>Number of Residents who:</b> Receive Supplemental Security Income: 1 Are 60 Years of Age or Older: 72 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 21 Have a Physical Disability: 7	

JUN 18 2013

Violation Report: 41019 - 05/29/2013 - Mazza, Larry  
 PCH Name: JUNIPER VILLAGE AT MEADVILLE

WEST REGION FIELD OFFICE  
 Human Services Licensing

**1. REGULATION 65 Pa.Code §2600**

2600.225(c) - The resident shall have additional assessments as follows:

- (1) Annually.
- (2) If the condition of the resident significantly changes prior to the annual assessment.
- (3) At the request of the Department upon cause to believe that an update is required.

**2a. DESCRIPTION OF VIOLATION**

Resident #1's current assessment, dated 9/15/12, indicates the resident requires no supervision. On 1/24/13, the resident was seen by the physician and the physician office visit form indicates the resident has suicidal ideation. Resident #1's assessment was not updated to address the suicidal ideation. On 5/16/13 at approximately 4:00 pm, resident #1 made the comment to staff member A, "Maybe I will just die." Staff member A inquired why the resident said that, and the resident responded, "I don't have anything to look forward to."

Then on 5/26/13, staff member B observed resident #1 sobbing and stating he/she wanted to die. Resident #1 had 6-8 scrapes, each approximately 1" in length, to the right side of the abdomen. This resident had a pair of scissors loosely pressed in a parallel position against the abdomen. Resident #1 was immediately hospitalized for an inpatient mental health evaluation.

Resident #1's current assessment does not address the resident's fall risk. However, according to the resident's progress notes and/or internal incident reports, the resident had unwitnessed falls as follows:

- \*Progress note, dated 11/19/12, "Slipped and fell in bathroom getting off of toilet."
- \*Progress note, dated 1/12/13, "Resident found sitting on the side of the tub after staff heard him yelling for help. Resident stated that he fell into the tub while getting up from the toilet.....small round skin tear about the size of a dime noted to outer right elbow area."
- \*Internal incident report, dated 5/14/13, "Resident was face down on the floor when I entered the room, after I heard a loud scream. It looked like he fell out of bed. Resident was a little confused and agitated that he fell. He says he does not know if he fell out of bed or if he fell out of wheelchair."

**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.

**Plan of Correction:**

All staff and new DOW will be re-trained on resident specific Support Plans. Due to the lack of space on a RASP, staff will be trained to add an addendum if needed. With the current utilization of our new electronic medical records program Point Click Care, any goals, interventions, focuses will be printed and attached to the RASP. Licensing Reps at the time of this specific visit indicated this was appropriate. DOW will also pull a report indicating all falls within the last year for all residents and make sure they are appropriately documented on the support plan and appropriate services are implemented. Training and fall audit to be completed by 7/6/2013.

Repeat Violation: No	Date(s) of Previous Violation(s):	09/19/2012
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Signature of Legal Entity Representative (Required on EVERY Page) *Jennifer C. Musone*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Jennifer Musone, Executive Director* Date *6/17/2013*

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

The above plan of correction is approved as of 7/9/13  
 (Date)

Plan of correction implementation status as of 7/9/13  
 (Date)

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

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

JUN 18 2013

Violation Report: 41019 - 06/20/2013 - Mazza, Lamy  
 \* PCH Name: JUNIPER VILLAGE AT MEADVILLE  
 WEST REGION FIELD OFFICE  
 Human Services Licensing

**1. REGULATION 55 Pa.Code §2600**  
 2600.227(d) - 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.

**2a. DESCRIPTION OF VIOLATION**  
 On 1/24/13, resident #1 was seen by the physician and the physician office visit form indicates the resident has suicidal ideation. The resident's current support plan, dated 9/15/12, was not updated to address the supervision needs of the resident due to suicidal ideations. On 5/16/13 at approximately 4:00 pm, resident #1 made the comment to staff member A, "Maybe I will just die." Staff member A inquired why the resident said that, and the resident responded, "I don't have anything to look forward to."  
 Then on 5/26/13, staff member B observed resident #1 sobbing and stating he/she wanted to die. Resident #1 had 6-8 scrapes, each approximately 1" in length, to the right side of the abdomen. This resident had a pair of scissors loosely pressed in a parallel position against the abdomen. Resident #1 was immediately hospitalized for an inpatient mental health evaluation.

According to resident #1's progress notes and/or internal incident reports, the resident had unwitnessed falls as follows:

- \*Progress note, dated 11/19/12, "Slipped and fell in bathroom getting off of toilet."
- \*Progress note, dated 1/12/13, "Resident found sitting on the side of the tub after staff heard him yelling for help. Resident stated that he fell into the tub while getting up from the toilet.....small round skin tear about the size of a dime noted to outer right elbow area."
- \*Internal incident report, dated 5/14/13, "Resident was face down on the floor when I entered the room, after I heard a loud scream. It looked like he fell out of bed. Resident was a little confused and agitated that he fell. He says he does not know if he fell out of bed or if he fell out of wheelchair."

Resident #1's current support plan does not address the service needs the home will provide to assist the resident in fall prevention.

**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 home's attached plan of correction*  
*See attachment # page 3A of 3*

Support Plan clearly states that resident suffers from depression and was being seen by VA Psych Services, and staff will monitor for isolation, increased sadness, lethargy, loss of appetite. MD was to be notified of any changes. Also, support plan indicates the mobile crisis team would be notified in the event of threats to harm himself. Although, the Mobile Crisis team was not contacted on 5/16/2013, there are many times resident was sent to the ER or mobile crisis was involved and resident was sent back with no changes noted by either organization. Mobile Crisis was called the day of the incident and willingly had resident sent to the ER because of the actual act of suicide. Staff have

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/19/2012
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Signature of Legal Entity Representative (Required on EVERY Page) *Jennifer Musone*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Jennifer Musone, Executive Director* Date *6/17/2013*

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 (Date)

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JUN 18 2013

## POC and Statement for Regulation 2600.227 (d)

WEST REGION FIELD OFFICE  
Human Services Licensing

Continued.....

addressed his concerns and behaviors with necessary parties. The residents depressive behaviors were often noted when he was seeking more medications. Resident had an appointment set with Niagra Therapy prior to this incident for addiction. This was not a significant change. Resident already had a diagnosis for depression noted on RASP and was prescribed a number of narcotics by PCP's. . These behaviors were typical for this resident and were manageable up until the incident on 5/26/2013. This resident never attempted to harm himself prior. These behaviors were noted just days after a medication change by the doctor. Staff listened to the concerns of this resident when he is exhibited signs of an altered mental status as well as informed the PCP. Staff spent time with resident and always offered suggestions and assistance. **Staff took all necessary precautions when they saw that the resident was causing harm to himself. PCH followed DPW guidelines with reporting. Resident did not return to PCH due to behavior management risks and was to be placed in an appropriate facility. PCP spoke with [REDACTED] and was agreeable with seeking higher level of care as a result of this instance to harm himself.**

**The resident has the right to seek their own medical provider. If the medical provider prescribes medications the PCH must comply with orders unless the resident refuses medications. The PCH staff can make recommendations and address concerns with PCP's etc. but it is up to the medical provider to assist the PCH with addressing the concerns. The PCH again made many attempts to get this resident help from PCP's and he was being seen by the VA Psych services.**

I do feel necessary behavioral services and other referrals were made and listed. The incident on 5/23/2013 was a significant change and RASP would have been updated upon residents return from Inpatient Mental Health stay.

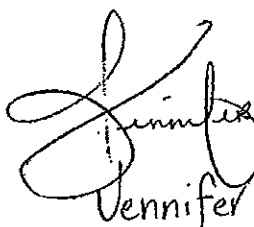
**Falls:**

Resident has had three falls since 11/19/12. He was assessed by PT and completed therapy as required or refused at times. PCH did fail to put falls on the RASP and is completing an audit as part of the POC for this violation.

**Plan of Correction:**

Falls program is in place but PCH failed to document residents falls on the support plan. An audit will be completed on all documented falls and added to the Support Plans. If there is not an adequate amount of room, an addendum will be attached as necessary. Audit to be completed by 7/6/2013.

Specific Behaviors for each resident along with interventions will be attached or included with the RASP as needed.

 Jennifer Musone, Executive Director  
Jennifer Musone

6/17/13

MARLA STEPANOVICH LMS 7/9/13  
Regional Licensing Approval of Plan of Correction  
marla stepanovich