pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Mailing Date: September 25, 2013
Sent via e-mail 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 June 11, 2013 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) 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,

Anne Graziano

Anne Graziano
Regional Licensing Administrator

Enclosure

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

PCH Name: THE VILLA ST ELIZABETH	License Number: 205761
Address: 1201 MUSEUM ROAD, READING, PA 19611	County: Berks
Administrator: Denise Kasaba	Region: NORTHEAST
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
Department of L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 73	Waking Staff: 55
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site

06/11/2013: Hummel, Jesse; Rushin, Julienne

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: 72	Receive Supplemental Security Income: 19
Secured Dementia Care Unit in Home: No	Are 60 Years of Age or Older: 71
Area:	Have Mental Illness: 31
Secured Dementia Unit Capacity, If Applicable:	Have an Intellectual Disability: 3
Number of Residents Served in Secured Dementia Care Unit, If applicable:	Have a Mobility Need: 1
Number of Current Hospice Residents: 1	Have a Physical Disability: 0
Number of Hospice Residents in past year: 1	

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.81(a) - The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

2a. DESCRIPTION OF VIOLATION

Department Representatives determined that resident #1 utilizes a walker to ambulate. It was determined that resident #1's room is located at the top of a ramp. In order for resident #1 to attend meals in the dining room or activities the ramp must be utilized. Resident #1 has had numerous falls while ambulating up and or down the ramp. It was determined through an interview with the resident as well as staff of the facility that resident #1 is not comfortable utilizing the ramp for fear of falling. Due to the resident fear of falling while ambulating on the ramp, the resident has eaten all meals in the residents bedroom and has not attended any activities since January 2013. The facility has failed to provide any physical site accommodations such as an alternate bedroom locate or equipment necessary to meet the safe ambulatory needs in order for resident #1 to safety move throughout the home.

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.

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #1.

This inspection was the result of a call to the DPW by a disgruntled ex-employee of the facility, who worked for the facility from 4-15-2013 to 5-30-2013. After her last day of work on 5-30-2013, she posted this unfounded and libelous allegation on her facebook page. Listed below are the accurate facts related to our Resident #1:

1. Resident #1 has been a resident at the home since June of 2008. His room is within forty feet on the same hallway as the owner's office door, which is always open. This resident has traversed the ramp leading from his room to the main dining room and back over all these years. The resident has played pinochle with the owner and other residents in the facility's living room and library.
2. Dr. [redacted] D.O. is Resident #1's primary care physician. On 6-28-2013, he provided the attached signed statement (see Attachment A). Dr. [redacted] has written: "[redacted] uses a walker to ambulate. He has no problem with this, and he is able to continue to reside in a personal care home. Also, there is no significant changes."
3. Attachment B is an affidavit signed by the Medications Administration Manager, [redacted] who has been employed by the facility since 2007, and has known and cared for Resident #1 since he was admitted in 2008. Presently, [redacted] continues to interact with Resident #1 daily. In her signed statement, she provides undisputed examples as to the mobility of Resident #1. She cites Resident #1's mobile ability to use Barta by himself for his doctor appointments outside the facility; ambulating to and from appointments within the facility, including stairs, etc. [redacted] was not interviewed by the inspector because she was scheduled off on 6-11-2013.

CONTINUED ON NEXT PAGE

Unacceptable Plan

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Brady

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jean BREADY ADM/OWNER Date 7-02-2013

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

The above plan of correction is approved as of 9-18-13 (Date)

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

Plan of correction implementation status as of 9-18-13 (Date)

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

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4. Unfortunately, on the day of the inspection, the Ramp Zone Aide, [redacted] was also scheduled off. This floor supervisor has worked at the facility since January 2002, and she has known and cared for Resident #1 for years. [redacted] has provided a signed affidavit - **see Attachment C.** [redacted] continues in her statement that Resident #1 can walk to and from the bathroom and to and from his meals.
5. [redacted]s Resident #1's POA and niece. She has recently been visiting Resident #1 less frequently due to her rehabilitation from surgery. She has confided that the disgruntled ex-employee attempted to "cause trouble by going to another family member with her unfounded accusations." [redacted] deflected the criticisms and advised the other relative to speak with [redacted] to receive accurate status reports regarding Resident #1. [redacted] has advised the Administrator and owner that Resident #1 gets a bit depressed and lazy when she misses her visits with him. [redacted] offers to answer any questions the DPW may have regarding the care and condition of Resident #1.
6. Only recently has Resident #1 requested meal tray service at times due to a flair-up in his diabetic condition and missing his niece's visits.
7. Resident #1 has attended activities in the library for the word games, the sun room for pinochle and the outside patio for the recent Memorial Day Barbeque. He has also evacuated for every fire drill with his walker – not a wheelchair.
8. The DPW inspector interviews of the staff, included a floater staff person, who mostly works the cottage and mansion zones. This aide has worked for the facility since January 2013. She has limited knowledge of the daily care and routines of Resident #1. Unfortunately, on the Tuesday of the inspection, the Ramp Zone Aide was scheduled off. This floor supervisor has worked at the facility since January 2002. The Med Adm Manager referred to in item #3 was also scheduled off. The inspector also interviewed two staff members, who were only slightly familiar with the ramp residents, since they primarily worked the cottage and mansion. One of those employees, [redacted] has signed a statement addressing Resident #1's mobility. (See **Attachment D**).
9. Finally, the inspector's interview with Resident #1 must be qualified by the fact that he has been depressed due to his niece's infrequent visitations due to her rehabilitation from her own surgery. Additionally, he stubbornly tries to not put his proper shoes on when he goes out to the rest room and dining room every day. His ramp Zone Aide must remind him regularly. These shoes support him properly to ambulate up and down the ramp.

In conclusion, Resident #1 is able and continues to move safely within the home and to his outside appointments.

Unacceptable Plan

JB

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9-16-2013 Addendum

– As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.81a is important to meet the needs of the residents in the facility in order to provide independence, enable a higher quality of life and promote rapid evacuation during an emergency.
2. A violation occurs when a facility fails to identify and correct a physical site accommodation to meet the health and safety needs of a resident.
3. The management of the facility did not change the accommodations of the resident, who allegedly was having mobility concerns.
4. This concern was fixed right away by the following actions taken by the administrator:
    a. a conference call was conducted with the family, primary physician and the administrator. It was agreed by all participants that the resident had no significant change in his mobility status.
    b. the resident's responsible party agreed with the physician and administrator that the resident had become mildly depressed because she had not visited him in a while. Resultantly, he became lazy in his behavior to put on the proper shoes to ambulate to the dining room. This was a direct result of the inappropriate actions of a an ex-aide, who found it easier to take the resident a tray instead of help him with putting his shoes on. This aide was separated from the facility two days before the complaint came into the DPW.
    c. the resident showed the family member, administrator and regular zone aide that he could traverse the ramp to and from his dining room, rest room and activities rooms, including the outdoor patio. As further evidence that the concern was cleared, the resident on his own with his walker took the Barta bus to his doctor appointment two days later.
5. To prevent future occurrences similar to this, the facility has included the following in its assessment and support logistics:
    a. All zone aides, shift supervisors and managers have been recovered on the facility's requirement to immediately report even the slightest change or lack of cooperation of the resident to ambulate to and from their meals, rest rooms, activities, etc.
    b. Resident behaviors and physical skills will be monitored and included in the quarterly assessment reviews.
6. The Administrator is the responsible management person to ensure on-going compliance to this regulation utilizing the assessment and support plan updates as her barometer.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative: JEAN BRADY RN OWNER - ADMIN Date: 9-16-13

Anne Grayson
9-18-13

Partially Implemented
Adequate Progress.

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.123(d) - If the home serves one or more residents with mobility needs above or below grade level of the home, there shall be a fire-safe area, as specified in writing within the past year by a fire safety expert, on the same floor as each resident with mobility needs.

2a. DESCRIPTION OF VIOLATION

Resident #1 utilizes a walker for ambulation and requires a wheelchair with assistance to evacuate in the event of an emergency. The home does not have fire safe areas and resident #1 currently resides in room 105 that is above grade level of the home and does not have a door leading directly to an at grade exit or a fire safe area within the home.
That level of the home does not have a fire safe area specified in writing within the past year by a fire safety expert.

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.

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #1.

Please refer to the Page 2 supporting documentation.

Unacceptable plan

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Brady

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jean Bready — Date 9-02-2013

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

The above plan of correction is approved as of 9-18-13 (Date)

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

Plan of correction implementation status as of 9-18-13 (Date)

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

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9-16-2013 Addendum

– As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.123d is important to ensure that a resident with mobility needs has a clear fire-safe zone to evacuate to that is on the same grade, floor or level.
2. A violation occurs when a facility has residents with mobility needs and does not have a specified fire-safe area on the same level.
3. As detailed in the facility's earlier replies, resident #1 was not earmarked as having any significant mobility change. This was supported by the primary physician, the family and the administrator. A facility will cause a violation if it does not properly accommodate the needs of an immobile resident.
4. This concern was fixed right away by the following actions taken by the administrator. Because of the positive findings of these actions, the resident was not deemed immobile, thus a grade level fire-safe zone was not required:
   a. a conference call was conducted with the family, primary physician and the administrator. It was agreed by all participants that the resident had no significant change in his mobility status.
   b. the resident's responsible party agreed with the physician and administrator that the resident had become mildly depressed because she had not visited him in a while. Resultantly, he became lazy in his behavior to put on the proper shoes to ambulate to the dining room. This was a direct result of the inappropriate actions of a an ex-aide, who found it easier to take the resident a tray instead of help him with putting his shoes on. This aide was separated from the facility two days before the complaint came into the DPW.
   c. the resident showed the family member, administrator and regular zone aide that he could traverse the ramp to and from his dining room, rest room and activities rooms, including the outdoor patio. As further evidence that the concern was cleared, the resident on his own with his walker took the Barta bus to his doctor appointment two days later.
5. To prevent future occurrences similar to this, the facility has included the following in its assessment and support logistics:
   a. All zone aides, shift supervisors and managers have been re-covered on the facility's requirement to immediately report even the slightest change or lack of cooperation of the resident to ambulate to and from their meals, rest rooms, activities, etc.
   b. At least monthly, when the resident census is updated, the staff will be canvassed to capture any and all resident mobility changes.
6. The Administrator is the responsible management person to ensure on-going compliance to this regulation regarding any changes to total resident capacity and mobility changes.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative: JEAN BRADY RN Date: 9-16-13

OWNER – ADMIN

Anne Grazier
9-18-13

Partially Implemented
Adequate Progress

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.124 - The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

2a. DESCRIPTION OF VIOLATION
Department Representatives determined through staff interviews that resident #1's mobility has declined. Resident #1 now requires the use of a wheel chair with physical assistance from staff to ambulate to the designated meeting place during fire drills. The facility failed to notify the local fire department of the change in resident #1's mobility needs and the assistance that would be required to evacuate resident #1 in the event of an emergency.

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.

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #1.

Please refer to the Page 2 supporting documentation.

Unacceptable Plan

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/12/2013		

Signature of Legal Entity Representative (Required on EVERY Page) Jean Brady

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jean BREADY — Date 07-02-2013

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

The above plan of correction is approved as of 9-18-13 (Date)

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

Plan of correction implementation status as of 9-18-13 (Date)

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

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9-16-2013 Addendum

—As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.124 is important to ensure the fire department has advance knowledge of the layout of the home and the needs of the residents to help them evacuate residents quickly.
2. A violation occurs when a facility fails to update changes to the fire department regarding:
    a. total capacity of the facility;
    b. general layout of the facility;
    c. residents with mobility needs.
3. The management of the facility did not notify the fire department of any changes in the above noted items. Resident #1 was not earmarked as having any significant mobility change as noted earlier.
4. This concern was fixed right away by the following actions taken by the administrator. Because of the positive findings of these actions, a letter to the fire department was not necessary:
    a. a conference call was conducted with the family, primary physician and the administrator. It was agreed by all participants that the resident had no significant change in his mobility status.
    b. the resident's responsible party agreed with the physician and administrator that the resident had become mildly depressed because she had not visited him in a while. Resultantly, he became lazy in his behavior to put on the proper shoes to ambulate to the dining room. This was a direct result of the inappropriate actions of a an ex-aide, who found it easier to take the resident a tray instead of help him with putting his shoes on. This aide was separated from the facility two days before the complaint came into the DPW.
    c. the resident showed the family member, administrator and regular zone aide that he could traverse the ramp to and from his dining room, rest room and activities rooms, including the outdoor patio. As further evidence that the concern was cleared, the resident on his own with his walker took the Barta bus to his doctor appointment two days later.
5. To prevent future occurrences similar to this, the facility has included the following in its assessment and support logistics:
    a. All zone aides, shift supervisors and managers have been re-covered on the facility's requirement to immediately report even the slightest change or lack of cooperation of the resident to ambulate to and from their meals, rest rooms, activities, etc.
    b. At least monthly, when the resident census is updated, the staff will be canvassed to capture any and all resident mobility changes.
    c. The computer set-up will trigger a fire department letter requirement if the census data includes any mobility changes.
    d. Likewise, any construction permit applications to change the facility's room and/or footprint blueprint will also trigger a requirement to forward a written notification to the fire department.
6. The Administrator is the responsible management person to ensure on-going compliance to this regulation regarding any changes to total resident capacity and mobility changes. The General Manager is the responsible management person to report any changes in the general layout of the facility.

Signature of Legal Entity Representative: Jeanne Brady

Print Name and Title of Legal Entity Representative: JEANE BRADY RN Date: 9-16-13
OWNER - ADMIN

Anne Grazioso
9-18-13

Partially Implemented
Adequate Progress

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.132(c) - A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

2a. DESCRIPTION OF VIOLATION
Department Representatives determined through staff interviews that resident #2 did not evacuate during the fire drill held on 5/31/13 at 5:21am. Staff person A who is responsible for evaluating and documenting all fire drills confirmed that resident #2 did not evacuate. It was determined that staff person A documented on the fire drill record that all 70 residents in the home at the time the alarm sounded evacuated to the designated meeting place. Staff person A stated "I didnt want to get resident #2 in any trouble for not evacuating."

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.

The management of the facility respectfully submits that NO VIOLATION against the 132c existed. The fire drill on the early morning of 5-31-2013 was staffed by four employees. The supervisor, [redacted] and direct care aides [redacted] and [redacted] have written and signed affidavits that Resident #2 evacuated the facility during the fire drill. **(See Attachments E & F).**

Staff Person A was overseeing the fire drill that morning and followed the facility's fire safety procedures properly. Staff Person A has been an employee of the facility since February 2007. Since that time, he has received several promotions and currently holds the position of Maintenance Manager. His duties include the responsibilities of the facility's Fire Safety Coordinator. He has performed his duties as Fire Safety Coordinator satisfactorily for over five years. On the morning of the fire drill, he confirmed his resident count with the on-duty supervisor [redacted] He then completed his recording of the drill. The signed affidavit of Staff Person A is attached **(See Attachment G)** confirming that all residents evacuated on the morning of 5-31-2013, and that his fire drill documentation was accurate. He has admitted in his signed statement that "..under nervousness I said a statement to the DPW inspector that was not correct."

The General Manager has covered Staff Person A on several occasions regarding his need for improving his on-the-job performance by listening to or partaking in idle conversation or gossip. This aligns with his statement about over-hearing after the drill that a resident was uncooperative during the drill, but he never saw that for himself. It is believed that this inability at times to ignore the distractions of idle talk led him to his incorrect statement to the inspector. Resultantly, Staff Person A has been relieved of his responsibility as Fire Safety Coordinator for the facility. He has been replaced by an individual with extensive fire safety and emergency preparedness experience.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/12/2013		

Signature of Legal Entity Representative
(Required on EVERY Page) Jean Brady

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) JEAN BREADY — **Date** 7-02-2013

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

The above plan of correction is approved as of 8-13-13 (Date)

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

Plan of correction implementation status as of 8-13-13 (Date)

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

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.132(f) - Alternate exit routes shall be used during fire drills.

2a. DESCRIPTION OF VIOLATION
Department Representatives determined that the facility has utilized "All Exits" during the previous four fire drills held on 4/11/13, 5/30/13, 5/31/13, and 6/10/13. The facility is not alternating exit routes during each fire drill as required.

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.

1. The management and staff of the facility understand the importance of Regulation 132f. By alternating the exit routes used for each fire drill ensures that staff and residents are prepared to respond to different fire scenarios.
2. Upon review of the attached Fire Drill Records from 1-8-2011 to present, the facility has shown a proper track record of varying the locations and exit routes of the fire drills with exception of the four dated 4-11-2013 through 6-10-2013.
    a. Although the locations used for the drills varied, the entries in EXIT ROUTES column failed to detail which exits were not used.
3. The cause of this violation was the failure of the Fire Safety Coordinator to complete the Fire Drill Records form properly.
4. This breakdown was immediately corrected by reminding and re-training the coordinator of his responsibilities.
5. Future occurrences will be prevented for the following reasons:
    a. as of 6-24-2013, the Fire Safety Coordinator has been demoted and relieved of his duties on-going.
    b. the General Manager has assumed the duties of the facility's Fire Safety Coordinator. He is very experienced and very knowledgeable of the Pennsylvania Fire safety Code as well as the related DPW regulations.
6. The General Manager and the Administrator will be responsible to insure future compliance to 132f.

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Brady

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Jean. BRADY — Date 7-02-2013

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

The above plan of correction is approved as of 8-13-13 (Date)

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

Plan of correction implementation status as of 8-13-13 (Date)

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

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

2a. DESCRIPTION OF VIOLATION
On 5/31/13 at 5:21am resident #2 refused to evacuate during the home's overnight fire drill. All residenst are required to evacuate during all fire drills.

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.

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #2.

Please refer to the Page 5 supporting documentation.

Unacceptable Plan

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Bready

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

Date 7-02-2013

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

The above plan of correction is approved as of 9-20-13 (Date)

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

Plan of correction implementation status as of 9-20-13 (Date)

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

 7A 89

9-15-2013 Addendum

– As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.132h is important as it provides for the safe designated meeting places away from the building or within fire-safe zones. This enables staff to ensure the residents are accounted for during actual fires and to support total evacuation and the prevention of death or injury from wandering.
2. A violation occurs when the facility has not designated a safe meeting place for the residents and/or if a resident fails to evacuate to the safe designated meeting places for a fire drill and/or actual fire.
3. The citation was caused by a staff member, who was not on duty during the noted fire drill, saying that a resident did not evacuate to his designated meeting place. The administrator has disputed this allegation as noted above.
4. The management of the facility has completed the following action items to clearly define the compliance to this regulation right away:
    a. The administrator has designed a new census format, which easily assists the zone aides on the number of residents in their respective zones.
    b. The administrator has created a "Magic Number Program", which requires each zone aide to know at all times how many residents they have in their zones.
    c. A radio communications system has been purchased by ownership, which enable the zone aides and administrator to efficiently confirm evacuated residents during an emergency.
5. To support on-going compliance of this important regulation, the tools identified above are used daily . The new design of the census enables the zone aides to check off actual names as they firm up their numbers during evacuations. The radios expedite the transference of numbers from each designated area and fire-safe zones.
6. The Administrator and her entire management team are the responsible management persons to ensure future compliance to this regulation. In addition to the regular fire drills of the facility, the staff is tested by the administrator routinely to ensure that all staff are aware of their respective Magic Numbers.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative : JEAN BRADY RN Date: 9-16-13

OWNR- ADMIN

Anne Grazier
9-20-13

Partially Implemented
Adequate Progress

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 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

Department Representatives determined that resident #1 has developed a mobility need. The resident requires the use of a wheelchair as well as physical assistance from staff to evacuate in an emergency. The residents most recent assessment and support plan completed on 10/31/12 has not been updated to include resident #1's change in mobility needs or how the home intends on meeting resident #1's mobility needs.

Resident #3 has a history of Irritability, Agitation, and physical Aggression. Most recently resident #3 assaulted resident #2. Resident #2 suffered a swollen left eye as well as lacerations above and below the eye. Resident #3's most recent assessment and support plan completed on 8/20/12 states the resident does not have any problem with Irritability, Agitation, or Aggression. The facility has failed to update resident #3's assessment and support plan to include these behaviors. The facility also failed to document the home's plan to keep resident #3 safe as well as ensure the safety of the other personal care home residents.

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.

Regarding Resident #1, the management and ownership respectfully submit that NO VIOLATION has occurred. Please refer to the Page 2 supporting documentation.

Regarding Resident #3, the management and ownership respectfully submit that NO VIOLATION has occurred for the following facts:

1. Resident #3 does not have a history of irritability, agitation and aggression. Per Officer [redacted] of the City of Reading Police Department, who responded to the 911 call from the facility, Resident #2 actually started the action by provoking Resident #3; thus, there was no assault and no charges asserted.
2. Resident #3 was moved that night into a private room and has been content and in good spirits since.
3. Based on the police summarization of the incident and Resident #3's controlled behavior, no special on-going staff plan was required to maintain a safe environment in the facility. The direct care staff and managers have continued their daily routines of caring and careful observation of Resident #2 and #3 as they do for all the residents.
4. The inspector refers to an 8-20-2013 assessment and support plan, when there was a signed and completed 6-10-2013 DME from Dr. [redacted] for Resident #3's annual evaluation. **(See Attachment H)**
5. The associated annual RASP package, also dated 6-10-2013, properly notes that Resident #3 has minimal problems with agitation, irritability and aggression. **(See Attachment I)**

Unacceptable Plan

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Bready

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) JEAN BREADY — **Date** 7-02-2013

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

The above plan of correction is approved as of 9-18-13 (Date)

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

Plan of correction implementation status as of 9-18-13 (Date)

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

8 Ag 9

9-15-2013 Addendum

– As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.225c is important as it provides the vehicle for the facility to create a comprehensive profile of a resident's needs. Additional assessments serve as basis for maintaining plans to meet the needs of the residents.
2. A violation occurs when a facility fails to update the resident's assessment if there is a significant change in the behavior of the resident.
3. The staff of the facility did not update the assessment of the resident based on the understanding of the particulars of the resident and the physician's condition report.
4. To fix any violations and stay ahead of any developing or changing conditions of the residents, a staff review was done. A complete audit of all resident assessment and support plans was accomplished to clarify the current profiles of all the residents. This was conducted by the Administrators, Med managers and zone aides.
5. To ensure on-going compliance to 2600.225c, the staff will participate in quarterly reviews of the residents they interact with to collect updated information, which might be important to escalate to the residents' physicians and responsible parties.
6. The Administrator is the responsible management person to ensure future compliance to this regulation, as she ultimately signs off on the assessment and support plans.

Signature of Legal Entity Representative: Kim Brady

Print Name and Title of Legal Entity Representative: KIM BRADY RN Date: 9-16-13
OWNER. ADMIN

Anne Grayson
9-18-13

Partially Implemented
Adequate Progress

Violation Report: 20576 - 06/11/2013 - Hummel, Jesse
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.226(a) - The resident shall be assessed for mobility needs as part of the resident's assessment.

2a. DESCRIPTION OF VIOLATION
Department Representatives determined that resident #1 has developed a mobility need. The resident requires the use of a wheelchair as well as physical assistance from staff to evacuate in an emergency. The resident's assessment dated 10/31/12 states the resident requires minimal assistance, is able to ambulate with a walker and is capable of evacuating during an emergency. The facility has failed to accurately assess resident #1's mobility needs and portray these mobility needs in resident #1's assessment as required.

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.

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #1.

Please refer to the Page 2 supporting documentation.

Unacceptable plan

See attached - 9/23/13 eq.

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

Signature of Legal Entity Representative (Required on EVERY Page) Jean Bready

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) JEAN BREADY — **Date** 7-02-2013

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

The above plan of correction is approved as of 9-23-13 (Date)

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

Plan of correction implementation status as of 9-23-13 (Date)

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

9-20-2013 Addendum

– As requested in the attached DPW letter dated 9-12-2013, the following addendum is provided. Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS?, which states: " Settings may document disagreement with a finding, and/or may document that providing a plan does not constitute admission that the listed violation is accurate. However, settings must provide a plan to correct each violation in addition to any statement(s) disputing the report's findings", the facility is complying with the following plan. The facility has disputed the findings on 7-02-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.226a stresses the importance of assessing the resident's mobility needs for it benefits both the resident and the facility. Identifying the resident's needs including mobility enables the facility to arrange for services and physical re-arrangements to accommodate the resident.
2. A violation occurs when a facility fails to identify , document and take the necessary corrective actions to assist the resident.
3. The management of the facility noted the assessment of the resident as requiring minimal assistance, which corresponded to the primary physician's evaluation. The earlier detail of the resident's condition underscores that he did not require a wheelchair. He, in fact, ambulated with his walker to doctor appointments, the rest rooms, the dining rooms and activities after the inspection as he did before. Nonetheless, in the spirit of establishing proper corrective plans in the event a resident has a significant change and requires mobility assistance, for example, the citation was caused by the assessment not matching the findings of the inspector.
4. This concern was fixed right away by the following actions taken by the administrator:
    a. a confab composed of the family representative, the primary physician, the facility med manager and administrator. It was agreed by all participants that the resident had no significant change in his mobility status.
    b. the resident's responsible party agreed with the physician and administrator that the resident had become mildly depressed because she had not visited him in a while. Resultantly, he became lazy in his behavior to put on the proper shoes to ambulate to the dining room. This was a direct result of the inappropriate actions of a an ex-aide, who found it easier to take the resident a tray instead of help him with putting his shoes on. This aide was separated from the facility two days before the complaint came into the DPW. The family member committed to "keeping the lines of communication more open with frequent calls and visits" in order to keep the resident in a more positive mood.
    c. the resident showed the family member, administrator and regular zone aide that he could traverse the ramp to and from his dining room, rest room and activities rooms, including the outdoor patio. As further evidence that the concern was cleared, the resident on his own with his walker took the Barta bus to his doctor appointment two days later.
5. To prevent future occurrences similar to this, the facility has included the following in its assessment and support logistics:
    a. All zone aides, shift supervisors and managers have been re-covered on the facility's requirement to immediately report even the slightest change or lack of cooperation of the resident to ambulate to and from their meals, rest rooms, activities, etc.
    b. Resident behaviors and physical skills will be monitored and included in the quarterly assessment reviews.
6. The Administrator is the responsible management person to ensure on-going compliance to this regulation utilizing the assessment and support plan updates as her barometer.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative: JEAN BRADY RN OWNER - ADMIN Date: 9-20-13

Anne Gozian 9/23/13