pennsylvania
DEPARTMENT OF PUBLIC WELFARE

Mailing Date: September 18, 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 18, 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
Regional Licensing Administrator

Enclosure

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

PCH Name: THE VILLA ST ELIZABETH	License Number: 205760
Address: 1201 MUSEUM ROAD, READING, PA 19611	County: Berks
Administrator: Jean Bready	Region: NORTH
Legal Entity Name: EVERGREEN ELDER CARE INC	
Legal Entity Address: 1201 MUSEUM ROAD, READING, PA 19611	

Certificate(s) of Occupancy

C-2 LP
09/20/1992
L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 71	Waking Staff: 53
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

06/18/2013: Novak, Ryan; Yeilenic, Cindy

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: 71	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: 0
Number of Current Hospice Residents: 1	Have a Physical Disability: 0
Number of Hospice Residents in past year: 2	

Violation Report: 20576 - 06/18/2013 - Novak, Ryan
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.16(c) The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION
At approximately 9:00pm - 11:00pm on 6/12/13 the home notified the police department of being unable to locate Resident #1. The home did not submit an incident report to the department for the use of a law enforcement agency.

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.

On the evening of 6-12-2013, Resident #1 was not in his room when the aide performed her rounds. Per the facility's protocol, the entire staff was requested to sweep the facility, and the supervisor placed a courtesy call to the resident's son. The son asked the supervisor to call the local police in case the resident was walking outside the facility. When the son arrived a few minutes later, the supervisor and the son went to the resident's room to see if the resident's boots and coat were in the room or if the resident had returned to his room. Upon arrival to the room, the resident was found lying in his bed. The supervisor then placed a follow-up call to the police to advise them of the false alarm. She explained that the resident was found in his bedroom.

A review of the RCG's Appendix A: Reportable Incidents guide for regulation 2600.16(c) supports the actions by the staff.

1. Item 5 – requires "... an unexplained absence of a resident for 24 hours or more or when the support plan so provides, a period of less than 24 hours ...". Since the resident was missing for a very short period of time and considering the fact that the sweep of the facility had not been completed, neither of these parameters apply.
2. Item 11 – Personal care homes are required to report any "incident requiring the services of an emergency management agency, fire department or law enforcement agency, except for false alarms." Since it was obvious that the resident had not left the facility and that he merely was away from his room for a short time, the call to the police department as requested by the son was both premature and resultantly, a false alarm.

To insure continued compliance to the DPW regulations, all staff members were re-covered on the proper procedures to follow when a resident is not in his/her room. After a thorough sweep of the facility and immediate property by the supervisor and staff, the supervisor will contact the designated person to be contacted in case of an emergency for the resident to confirm the resident is not with him/her and failed to sign out. Once the supervisor has confirmed that the resident is not in the facility and not out of the facility with his/her designated person, the supervisor will contact Administrator, the owner and the police department. A reportable incident form will then be created for the DPW.

Unacceptable Plan

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) J. BRADY ADM-DIRECT **Date** 8-3-13

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

The above plan of correction is approved as of 9-17-13 (Date)

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

Plan of correction implementation status as of 9-17-13 (Date)

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

2 A 3

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 8-03-2013 (see above). In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.16c is important report incidents and conditions to the DPW's personal care home regional office as it demonstrates the facility's commitment to regulatory compliance.
2. A violation occurs when a facility fails to report an incident within 24 hours to the DPW's personal care home regional office.
3. The staff of the facility did not forward a report to the DPW's personal care home regional office. The circumstances of the incident appeared to the staff to not require filing a reportable incident.
4. This was fixed right away when the Administrator covered all staff members to follow the DPW's recommendation "when in doubt, send it out" rule: if you have to ask, you should send it out.
5. To prevent future occurrences similar to this, the facility has streamlined its Incident Reporting Procedures as follows:
    a. All shift supervisors and managers have been covered with the RCG- Part 3 – Appendix A: Reportable Incidents.
    b. All incidents involving residents and/or staff will be reviewed by the manager on duty at 4pm and 7am every day for each of the seven days of the week.
    c. The manager on duty will forward the reportable incidents to the DPW regional office.
    d. All incidents – reported to the DPW and lesser house incidents - will be forwarded to the Administrator for her review and ensuing approval.
6. The Administrator is the responsible management person to enforce this strict adherence to the reportable incident policy and continue to supervise the daily processing of all incidents.

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 Grazier 9-17-13

Partially Implemented - Adequate Progress.

Violation Report: 20576 - 05/18/2013 - Novak, Ryan
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

The annual assessment for Resident #1 dated 6/10/13, did not include the resident's mental health diagnosis and the appropriate level of supervision. The resident has a court appointed guardian for Resident #1's person and estate which must be considered when assessing this resident's needs and determining needed services. Resident #1's appointed guardian is not addressed anywhere throughout the Resident Assessment Support plan. The home assessed Resident #1's judgment as having no problem. On 4/24/13 Resident #1 got into a physical altercation with Resident #2. On 6/12/13 the facility could not locate Resident #1. Resident #1 was located in the bathroom approximately 8 feet from his bedroom. Resident #1 was aware the home was looking for him, but failed to answer calls from staff as well as staff person's knocking on the bathroom door that Resident #1 was utilizing. The summary section (III) of the Resident Assessment and Support Plan was not filled in with the information pertinent to the resident's medical, psychological, and social health and how the facility would maintain or improve the resident's overall wellness. The home's assessment failed to reflect Resident #1's needs.

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 NEXT PAGE →

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/11/2013		

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J. BRADY OWNER/ADM

Date 8-3-13

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

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

3A of 3

The management and ownership respectfully submit that NO VIOLATION has occurred related to Resident #1. Regulation 2600.225(c) has not been violated in relation to Resident #1. This is the second cited violation of this regulation within one week of each other and neither of them are violations.

Just seven days prior to this inspection of 6-18-2013, an inspection was conducted on this same topic. On 6-11-2013, an inspector cited 2600.225(c), and the management and ownership disputed the finding as a NO VIOLATION. **(Please see Attachment A - 15 pages).**

During this inspection conducted on 6-18-2013, another inspector cited the facility again for the same circumstances related to the same resident. Again, the management and ownership respectfully submits that there is NO VIOLATION. The following documentation is provided in response to the DESCRIPTION OF VIOLATION section above.

1. The DME completed on 6-10-2013 by Dr. [redacted] had no mental health diagnosis; thus, the assessment did not include a mental health diagnosis. On the form DPW – ARL- RASP Page 8 of 11, the instructions clearly state: ASSESSMENT – MENTAL HEALTH NEEDS. MEDICAL DIAGNOSES – Psychological. Using the Documentation of Medical Evaluation Form from the most recent medical evaluation, list all of the resident's diagnoses. *Example: Schizoprenia* . The form was completed correctly by the Administrator as NONE, which properly matched the doctor's evaluation.
2. The appropriate level of supervision is accurately included on RASP Page 5 of 11 as moderate.
3. The resident's records include the court order appointing his guardian of estate and person. His guardian of person is his son, who is properly noted as his designated person. According to the court order, the guardian of person has the authority and responsibility to decide where the resident shall live and how meals, personal care, transportation and recreation will be provided, as well as medical treatment and surgical procedures. The Administrator of the facility has interacted professionally with the resident's son in all aspects of his care; however, no notations or dependent actions on the RASP have been required.
4. Resident #1's judgment was properly noted as not harmful to self or others. The DPW inspector was advised that the findings of the investigation of the 4/24/13 altercation by the police and the Administrator was that the resident was provoked by the other resident. His judgment was not subjected to criticism. The RASP Page 9 of 11 properly details his irritability and aggression degree of behavior as minimal problems. On 6-12-2013, the resident was missing for a short period of time, and then found in his bed by the third shift supervisor. He was not found in the bathroom as stated in the section above. The third shift supervisor signed an account of the incident. Please see Attachment B. The Administrator discovered in her investigation that the portion of the addendum to RASP entry made by the second shift supervisor regarding him stating he was hiding in the bathroom was not accurate, as the second shift supervisor was not present when the resident was found in his bed.
5. Part III Summary and Determination – RASP Page 11 of 11 – was completed purposely and properly by the Administrator. At the exit meeting on the day of the inspection, the Administrator explained that she had been taught by another DPW inspector that if she included significant changes and comments on improving quality of care in each section, then it was not necessary to re-type that data in the summary section.
6. The facility's RASP detailed thoroughly the needs of resident #1.
7. Please note that Resident #1's time is a wonderful example of a Personal Care Home's Success Story. He applied to the facility with nowhere else to go. The owner and Administrator worked closely with his son to match the resident's behavior and social profile with a healthy and safe living environment. They were careful not to make assumptions or pre-judge him just because of his quiet demeanor. Initially, the April altercation was believed to be his fault until further investigation proved otherwise. Ownership's unselfish approval to move the resident to a private room was in his best interests. He now cooperates with his personal care and room cleanliness. The resident now attends activities regularly. His guardians are very pleased with his progress.

B

Unacceptable Plan.

3893

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 8-03-2013 (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: Jean Brady

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

OWNER - ADMIN

Anne Grasso 9-17-13

Partially Implemented - Adequate Progress