



**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 July 3, 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: 20578 - 07/03/2013 - Novak, Ryan  
 PCH Name: THE VILLAS ELIZABETH

**1. REGULATION 55 Pa.Code §2600**

2600.15(b) - If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

**2a. DESCRIPTION OF VIOLATION**

On 7/1/13 the home was made aware of an alleged abuse against staff person A regarding Resident #1 from the Berks County Area Agency on Aging. Staff person A worked 3pm-11:15pm on 7/1/13. The home did not develop and implement a plan of supervision until 7/2/13 at 3:00pm.

The home removed Staff person A from the plan of supervision on 7/2/13 at 3:00pm after consulting with the Berks County Area Agency on Aging without notifying the Department.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pieces.)

Foremost, the allegation of abuse from 7-1-2013 has been closed out as totally unsubstantiated by the Office of the Aging and the DPW ARL. The implementation of a plan of supervision as outlined in 2600.15(b) is important to protect the safety and welfare of all involved parties, and the Administrator immediately initiated her investigation and preliminary plan of supervision after David Kampe from Office of the Aging left the facility at 4:30PM on 7-01-2013. She pulled the affected staff person from the floor and interviewed her. Because of the late hour of the evening and the fact that the staff person was one of only two med-techs scheduled that night, the shift supervisor was then assigned to closely supervise the staff member the remainder of the evening. Since the staff member was scheduled off the next day, a written plan of supervision was not completed until before her 3:00PM shift on 7-3-2013. As the inspector noted above, the plan of supervision to re-assign the staff person to another zone and be monitored by the shift supervisor was completed prior to her 3:00PM start time on 7-03-2013. Resultantly, this specific regulation 2600.15(b) was not violated by the Administrator.

On Friday, July 12, 2013, [redacted] visited the facility at 3:15PM and conducted his final interview with the staff member. He then advised the General Manager that was no substantiation to the allegation of abuse. He asserted that our Plan of Separation for the wrongly accused staff member should be terminated, and the employee was authorized to resume he normal schedule of responsibilities. The Administrator and manager then called the DPW office, reached a voice mail and left a corresponding message of exoneration. The Administrator also e-mailed a final correspondence reiterating the directives of David Kampe closing the investigation and terminating the plan of separation. See Attachment A.

In the interest of compliance on an on-going basis, the Administrator and management have been covered on the Suspected Resident Abuse Reporting and Investigation Requirements. Fortunately, the management team had not been confronted with an abuse allegation in the past, and the training session was effective.

Ownership and management will all be responsible to prevent any and all abuse allegations. In the unfortunate event, if a case were to surface, the proper creation of a plan of supervision will be that the personal responsibility of the Administrator.

*unacceptable Plan*

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

Signature of Legal Entity Representative (Required on EVERY Page) *J. Bready*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *J. Bready - Owner / ADM*      Date *8-3-13*

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

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

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

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

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

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9-15-2013 Addendum

- As requested in the attached DPW letter dated 9-13-2013, 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 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 2600.15b is important to ensure the staff person involved in an alleged incident is immediately separated or suspended from the alleged resident's living area in the interests of safety of all concerned.
2. A violation is cited when the facility does not immediately enact a plan of supervision for the staff person.
3. Per the inspector, the plan of supervision should have been written.
4. This was fixed right away per the inspector's instructions. A written plan of supervision was created by the administrator and given to the inspector. This was accomplished prior to the arrival of the staff person, and it assigned her to another position in a remote location of the facility. It included frequent supervisory attention to confirm compliance to the new assignment.
5. To prevent future occurrences similar to this, the facility has covered all management staff on the RCG's Abuse and Abuse Reporting Guidelines and flowchart. In the event of an allegation, a plan of supervision will be created and enforced immediately and forwarded to the DPW regional office. The facility will maintain the plan of supervision until the DPW regional office authorizes the facility to terminate the plan.
6. The administrator is the responsible management person to ensure the proper on-going compliance to this regulation. The gravity of the situation is well understood, and the plan and reporting procedures will be will be purppesly implemented in the event of any allegation.

Signature of Legal Entity Representative: \_\_\_\_\_

*Jean Bready*

Print Name and Title of Legal Entity Representative: \_\_\_\_\_

*JEAN BREADY RN*

Date: *9-17-13*

*OWNER - ADMIN*

*Anne Hayes*  
*9-18-13*

*Partially Implemented  
Adequate Progress*

Violation Report: 20578 - 07/03/2013 - 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  
On 7/1/13 the home was made aware of an allegation of abuse by staff person A to Resident #1 from the Berks county Area Agency on Aging. The home did not submit an incident report to the Department of the alleged abuse until 7/4/13.

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.

Technical assistance had been requested to clarify the requirement of a reportable incident to both the ARL and AAA. Regulation 2600.16(c) states that a reportable incident report is required, and abuse reporting shall also follow 2600.15. This is confusing, since the Administrator was uncertain of the primary point of contact. Regulation 2086.15(a) refers to the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707 - See Attachment B). Following this statute, the Administrator made an oral report to the Area Agency for Aging. Then within 48 hours, the Administrator forwarded the ACT 13 form to the agency. Following the flowchart of Suspected Resident Abuse Reporting and Investigation Requirements in the RCG, a reportable incident was forwarded within 24 hours of completing the ACT 13 form. The DPW Inspector, who visited the facility on 7-03-2013, advised the Administrator that the reportable was due within 24 hours of the initial contact by the AAA. However, during that brief meeting, [redacted] only asked for a copy of the resident's medications and a copy of the schedule.

The Administrator requests the DPW to provide technical assistance to clarify the proper protocol of the reporting by the facility. Fortunately, the infrequency of dealing with abuse allegations has clouded the reporting procedures. In this case, the facility was initially contacted by the AAA, the internal investigation was completed and forwarded to them and their representative then came back on 7-12-2013 and cleared the staff member and closed the allegation as unsubstantiated. All the while, the Administrator was forwarding copies of these correspondences to the DPW. The flowchart and the 35 P.S. Sections imply that the AAA is the lead point of contact, which will investigate the case and determine the outcome. To receive a violation in the reporting or handling of this incident appears shallow with relation to the altruistic goals of investigation, resolution and ultimately prevention of abuse cases.

The length and depth of the 30 page internal investigation created by the Administrator reflects the facility's high degree of commitment to the gravity of the allegation case. (See Attachment C). The facility management believed it was following the proper reporting procedures based on the above references. Nonetheless, the Administrator and owner have trained themselves on the parallel reporting requirements to both agencies - the AAA and ARL. They are responsible for the on-going compliance to this regulation.

Unacceptable Plan

Repeat Violation:  Yes  No <sup>JB</sup> Date(s) of Previous Violation(s): 06/18/2013 <sup>Disputed - NO VIOLATION JB</sup>

Signature of Legal Entity Representative (Required on EVERY Page) *J. Poleady*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J. Poleady - Owner / Adm Date 8-3-13

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The above plan of correction is approved as of <u>9-18-13</u> (Date)	Plan of correction implementation status as of <u>9-18-13</u> (Date)
The above plan of correction was approved by <i>OP</i> (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

P 3 A 8 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. The regulation was cited because the facility sent the reportable incident to the DPW regional office within 24 hours of the time it notified the Area Agency of the Aging. The interpretation of the facility was that the AAA was the primary point of contact and the DPW report followed that. Thus, the report was received at the DPW regional office late although a complete incident report was provided to the inspector the day before.
3. The citation was caused by the mis-interpretation of the flowchart timeline where the AAA was to receive an initial report and the DPW.
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, as well as the abuse reporting guidelines and flowchart.
  - b. In the case of any allegation, the facility will parallel report immediately to the DPW regional office and the AAA.
6. The Administrator is the responsible management person to enforce this strict adherence to the reportable incident policy, especially as it relates to any allegations. She will ensure on-going compliance.

Signature of Legal Entity Representative:

*Jean Bready*

Print Name and Title of Legal Entity Representative:

JEAN BREADY RN

Date:

9-17-13

OWNER-ADMIN

*Anne Graziano*

9-18-13

*Partially Implemented Adequate Progress*