COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

CERTIFICATE OF COMPLIANCE

This Certificate is hereby granted to **EVERGREEN ELDER CARE INC**
(LEGAL ENTITY)

To operate **THE VILLA ST. ELIZABETH**
(NAME OF FACILITY OR AGENCY)

Located at **1201 MUSEUM ROAD, READING, PA 19611**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

(ADDRESS OF SATELLITE SITE) (ADDRESS OF SATELLITE SITE)

To provide **Personal Care Homes**
(TYPE OF SERVICE(S) TO BE PROVIDED)

The total number of persons which may be cared for at one time may not exceed **92** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Public Welfare Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 18, 2013** until **November 18, 2014**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: 205760

Robert E. Robinson
ISSUING OFFICER

ACTING DIRECTOR

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

PW 628 – 10/13

pennsylvania
DEPARTMENT OF PUBLIC WELFARE

NOV 1 8 2013

Ms. Jean Bready, Owner-President
Evergreen Elder Care Inc.
1201 Museum Road
Reading, Pennsylvania 19611

RE: The Villa St. Elizabeth
License #: 205760

Dear Ms. Bready:

As a result of the Department of Public Welfare's (Department) licensing inspection on September 5, 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 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.

A regular license is being issued based on the enclosed License Inspection Summary. Your license is enclosed.

Sincerely,

Matthew J. Jones
Acting Director /SH

Enclosures
License
License Inspection Summary

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

PCH Name: THE VILLA ST ELIZABETH	**License Number:** 20576
Address: 1201 MUSEUM ROAD, READING, PA 19611	**County:** Berks
Administrator: JEAN BREADY	**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
PA L&I

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 71 **Waking Staff:** 53

Type of Inspection: Full **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)

Renewal, Provisional, Complaint

On-Site Inspections Dates and Department Representatives On-Site

09/05/2013: OHaire, Anne; Novak, Ryan; Harvey, Jason

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 Served: 71

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: 2

Number of Residents who:

Receive Supplemental Security Income: 23

Are 60 Years of Age or Older: 64

Have Mental Illness: 47

Have an Intellectual Disability: 3

Have a Mobility Need: 0

Have a Physical Disability: 0

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION
The binder labeled annual licensing inspections located outside of Administrator's "A"office contained a DME and RASP for Resident # 1. These documents contained confidential information and were accessible to anyone in 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 home submitted a plan of correction for the original violation of 3-12-13 on 4-18-13. The home failed to implement that plan of correction.

Disregard
11-14-13

See next page

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

Signature of Legal Entity Representative (Required on EVERY Page) [signature]

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J Brady - Owner - Adm

Date 10-4-13

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

The above plan of correction is approved as of 11-14-13 (Date)

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

Plan of correction implementation status as of 11-14-13 (Date)

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

The management of the facility respectfully submits that this citation is not appropriate for the following reasons:

1. For over thirteen years under the current ownership, the facility complied with the regulations 2600.3c of the LMI and then RCG. The posted inspections and related violation report replies always contained the attachments necessary to support the facility's responses. Additionally, the facility included the cross-referencing documents – Resident and Staff Privacy Coding Documents.
2. During the 3-12-2013 inspection, the facility was cited for having Resident and Privacy Coding Documents in its posted inspection book. During that inspection, the facility administrator removed these documents immediately while the inspectors were still on the site. Nonetheless, the inspector violated the facility for having those documents in the book.
3. In the 4-18-2013 violation report reply to the DPW, the administrator requested the help of the DPW staff to clarify the following:
    a. *"It is requested by the management of the facility that the DPW amend Regulation 2600.3c to specify the omission of the resident and staff privacy coding documents when posting the current license inspection summaries in a public place. This would clarify the proper compliance to Regulation 2600.3c. Additionally, the form – Resident Privacy Coding Document – is requested to be listed as part of the resident records as detailed in Regulation 2600.252 – Content of Resident Records".*
    b. As of this date, the DPW staff has not responded to this request for help.
4. During that same 3-12-2013 inspection, two other inspection replies – 8-29-2012 and 1-10-2013 – were posted in the same book the inspector cited the facility for the 3-12-20123 reply having the Resident and Staff Privacy Coding Documents. Both of these reports contained attachments to support the facility's responses to citations noted by the inspectors of the two inspections – 8-29-2012 and 1-10-2013. The inspector did not mention to the management of the facility nor did the inspector violate the facility for the attachments having the names of residents in them.
    a. ATTACHMENT A - the 8-29-2013 facility reply to the DPW dated 9-21-2013 included copies of a resident's power of attorney as well as a lease executed by the resident's POA.
    b. ATTACHMENT B – the 1-10-2013 facility reply to the DPW dated 2-1-2013 included a copy of a physician's memo which included the name of the resident.
5. The facility management submits that the inspector during the 3-12-2013 inspection reviewed the facility's inspection book and overlooked the attachments with residents' names on them, yet violated the facility only on the Privacy Coding Documents. Had the inspector cited the attachments as well, they would have been immediately removed as the Privacy Documents were. Accordingly, the inspector during the 9-5-2013 inspection would have not discovered any attachments with residents' names just as the inspector did not find any Privacy Coding Documents.
6. Additionally, the DPW failed to respond to the facility's formal request for assistance from 4-18-2013 (see paragraph 3a above). The administrator feels there was ample time for the DPW to acknowledge the facility's request for assistance between the 4-8-2013 request date and the date of this inspection – 9-5-2013.

Adhering to Page 28 of the DPW Licensing Reference Manual (9-1-2013 edition) Can settings dispute a finding on the LIS2, 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 by presenting the following plan. The facility has disputed the findings noted on Section 2a above. In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.17 is important because it protects resident privacy and ensures the confidentiality of all resident records. The facility has always been committed to insuring that privacy of resident records and remains committed on-going.
2. The regulation was violated because the inspector discovered two attachments to an appeal of a previous violation report did not have the resident's name blacked out. Resultantly, the resident's name was unwittingly accessible to anyone who would read the response to the earlier inspection.
3. The cause of this action was the confusion on the part of the management team of the facility. On 4-8-2013, the administrator requested assistance from the DPW relating to this particular violation (see above), because it was felt that the regulation requiring the posting of past inspections and related violation report replies – 2600.3c – differed with 2600.17.
4. The violation was corrected immediately on the day of the inspection while the inspectors were still at the facility.
5. The facility has completely instilled its measures to prevent future occurrences. All replies to inspection findings (including this reply) are duplicated before transmittal to the DPW. The duplicate copy is then be earmarked as the copy to be placed in the facility's inspection book.
6. The administrator will personally initial all attachments confirming the proper blacking out of all private information for the prevention of future violations.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative: J. Brady owner – Date: 10-4-13

11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.65(e) - Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

2a. DESCRIPTION OF VIOLATION
Direct Care staff member "B" only completed 10 of the 12 hours of required training for the 2012 training year

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. Regulation 2600.65e is important to ensure that the facility's direct care staff persons receive high quality training to continue to develop their knowledge of regulatory requirements and best practices in resident care.
2. This regulation was violated because of the administrator-instructor did not confirm on the day of the training that staff member B was in attendance for the Emergency Preparedness Training on 12-17-2012. Staff member B had not signed the attendance sheet. By not receiving credit for the Emergency Preparedness Training, staff member B accumulated only 11 hours of her annual training requirement instead of the requirement of 12 hours per year.
3. The training instructor took a roll call and passed around the sign-in sheet for her Emergency Preparedness Training. She failed to properly review the training attendance documents and proceeded to present the personnel department with an inaccurate form resulting in staff member B receiving credit for the Emergency Preparedness Training.
4. To fix this problem right away, the facility management team instituted the cross-checking of the training attendance sheet with the personnel department's employee file forms. Both the administrator and personnel manager must cross-check and sign off to insure accuracy. (Addendum note 11-12-2013: Additionally, staff member B has been scheduled to be trained on the Emergency Preparedness Plan on 10-29-2013. This training was completed and designated to cover her missed 2012 training requirement per the DPW. Staff member B will then be trained again on the Emergency Preparedness prior to 12-31-2013 and this training will be credited to her 2013 training requirements.)
5. The administrator, personnel manager and company database manager are required to confer as to the validity of all employee training documents. Additionally, the creation of a streamlined employee training database serves to safeguard accuracy and prevent future violation.
6. The administrator, personnel manager and database manager, individually and collectively, are responsible to process the all training documents through the three-way cross-check and the proper input into the computer database.

ADDENDUM note ADDED 11-12-2013 Jean Bready adm.

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)	J. BREADY, OWNER		**Date**	10-4-13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
(3) Resident rights.
(4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
(5) Falls and accident prevention.
(6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION
Direct Care staff member "B" did not receive training in emergency preparedness for the 2012 training year.

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. Regulation 2600.65g is important to ensure that the facility's direct care staff persons are reminded of the facility's emergency procedures and mandated reporting requirements. This regulation requires the facility to train annually on essential care procedures including emergency procedure, falls, etc.
2. This regulation was violated because of the administrator-instructor did not confirm on the day of the training that staff member B was in attendance for the Emergency Preparedness Training on 12-17-2012. Staff member B had not signed the attendance sheet. By not receiving credit for the Emergency Preparedness Training, staff member B accumulated only 11 hours of her annual training requirement instead of the requirement of 12 hours per year. (Addendum note 11-12-2013: Please see Attachment DD, which lds the 2012 training summary for staff member B. It details that she had accumulated 11 hours of her 12 mandatory hours. Her 2012 training on the Emergency Preparedness Plan was conducted on 10-29-2013.) Had this breakdown been caught at the time, individual training could have be given to staff member B to achieve her annual requirement.
3. The training instructor took a roll call and passed around the sign-in sheet for her Emergency Preparedness Training. She failed to properly review the training attendance documents and proceeded to present the personnel department with an inaccurate form resulting in staff member B receiving credit for the Emergency Preparedness Training.
4. To fix this problem right away, the facility management team instituted the cross-checking of the training attendance sheet with the personnel department's employee file forms. Both the administrator and personnel manager must cross-check and sign off to insure accuracy.
5. The administrator, personnel manager and company database manager are required to confer as to the validity of all employee training documents. Additionally, the creation of a streamlined employee training database serves to safeguard accuracy and prevent future violation.
6. The administrator, personnel manager and database manager, individually and collectively, are responsible to process the all training documents through the three-way cross-check and the proper input into the computer database.

ADDENDUM Note ADDED 11-12-2013 Jean Bready Adm.

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) J. BREADY - OWNER **Date** 10.4.13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-15 (Date)

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

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.93(a) - Each ramp, interior stairway and outside steps must have a well-secured handrail.

2a. DESCRIPTION OF VIOLATION
The door leading from the cottage's lower level dining room to the home's designated smoking has a step-down of 6 inches; the home does not have a well-secured handrail for the step-down.

The Egress from the 1st floor fire escape located next to room #144 in the home's cottage area has steps; the home does not have a well-secured handrail for the steps.

The Egress from the 1st floor fire escape located next to room #142 in the home's cottage area has steps; the home does not have a well-secured handrail for the steps.

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

Addendum Note Added
11-12-2013
Jean Brady Adm.

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) J. BRADY - OWNER

Date 10.4.13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

The management of the facility respectfully submits that this citation by the inspector is not appropriate because an inspector on the previous full inspection less than six months earlier on 3-12-2013 cited this same regulation for only in interior door with a one step down. At that time there was no discussion nor citation by the inspector on the exit doors by room 144, 142 and the lower dining room. Additionally, the facility has not changed its physical site blueprint and has not added or modified any doorways or exits during the more than thirteen years of the current ownership. The management added a grab bar to the one step interior doorway cited on the 3-12-2013 inspection.

Again, had the exits been cited during that 3-12-2013 inspection, the facility would have taken immediate action to comply. Instead, the management understood these exit doors by rooms 144, 142 and the lower dining room as being only about three inches above grade. Since the 93a regulation cites "outside steps" – plural - and the fact that there was never a previous discussion by a DPW inspector throughout the years, the management understood that these doorways were not covered by this regulation.

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 by presenting the following plan. The facility has disputed the findings noted on Section 2a above. In the spirit of compliance with the LRM, the required plan is submitted below:

1. Regulation 2600.93a is important to ensure the safety of the residents, their families, the staff and visitors by preventing trips and falls. Compliance to this regulation prevents falls and provides for the safe evacuation during emergency evacuations.
2. This regulation was violated because the inspector believed that the exits near rooms 144, 142 and the lower dining room are covered by this regulation.
3. This citation was caused by the fact that the facility has never had grab bars installed at these exits because of the slight difference from floor level to the ground level.
4. To fix this right away, the facility installed handles to the doorways for each of these exits.
5. The installation of handles will now prevent any future citations by the DPW inspectors. (Addendum not 11-12-2013: The administrator and maintenance manager will conduct a monthly property and building inspection to insure the proper condition and locations of the handles and handrails. Evaluations will be noted to the need for additions or replacements during this inspection.)
6. Unless the facility undergoes construction of additional exits or interior modifications, there will be no other locations requiring handles or handrails. The administrator and maintenance manager will be responsible for on-going compliance to this regulation.

ADDENDUM Note ADDED 11-12-2013 Jean Bready Adm.

Signature of Legal Entity Representative: Jean Bready

Print Name and Title of Legal Entity Representative: J. BREADY-Admin Date: 10-4-13

Anne Glazier 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION
The Kenmore dryer lint trap located in the home's basement was caked full of lint.

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

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

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

Date 10-4-13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.105g is especially important to ensure the safety of the residents and staff of the facility. The removal of lint is paramount in the facility's efforts to maintain a safe environment.
2. This regulation was violated because a load of newly-purchased towels were washed and dried in one dryer the morning of the inspection and the aide failed to clean out the lint trap.
3. The facility's laundry is processed every night and the aides are required to remove lint from the dryer lint traps after each use. After the 3rd shift supervisor inspected the machines and locked up the laundry room at 7 AM on 9-5-2013, a 1st shift aide was instructed to wash and dry some newly-purchased towels. This aide failed to clean the lint trap after the towels were dried. The new towels always create extra lint when initially washed, which supports the inspector's observation.
4. To fix this problem right away, the facility management team has restricted use of the laundry to only the 3rd shift supervisors. Under their supervision, the facility has meticulously complied with the fire safety requirements while using the clothes dryers. The laundry room lock has been re-keyed to restrict all other access.
5. To prevent future violations, the facility management team has established the following enhanced rules for the use of the laundry room:
    a. Access to the laundry room is prohibited without prior authorization of the administrator;
    b. The 3rd shift supervisors will continue to carefully oversee the nightly laundry operations. They will continue to supervise hourly that their subordinates are keeping the lint traps cleared throughout the night.
    c. After the 3rd shift supervisor closes the laundry each morning, the maintenance manager will inspect the lint traps;
    d. both the out-going 3rd shift supervisor and the maintenance manager will sign a daily cross-check form that all lint traps are clean and the equipment is working correctly.
    e. The administrator or med manager in her absence will be the only individuals that allow access to the laundry room during the 1st and 2nd shifts.
    f. This restriction will be supported by changing the lock of the laundry room door.
    g. The administrator / med manager will sign in and out and specify the activity.
    h. All lint traps will be inspected before and after each such usage.
6. The administrator and med manager will be individually and collectively responsible to ensure the proper usage of all the laundry equipment, especially the dryers and their respective lint traps.

Signature of Legal Entity Representative: Glenn Brady

Print Name and Title of Legal Entity Representative: O.J. Brady Date: 10-4-13

Anne Alonzo 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600
2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
Resident # 2 was admitted to the home on 10/26/2012, the medical evaluation indicates the resident was evaluated on 5/2012, more than 60 days prior to being admitted to 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.

See Next Page

Repeat Violation: No	Date(s) of Previous Violation(s):			
Signature of Legal Entity Representative (Required on EVERY Page)	Colleen Brady			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	J BREADY OWNER		Date	10-4-13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.141b1 is important to ensure that the facility administrator and management always has the most accurate and updated medical information for their residents. The annual medical evaluation must be current to enable the facility to properly meet the needs of the residents, while help the development of accurate assessments and support plans.
2. This regulation was violated at the time of admission of the resident. The med manager and administrator failed to see that the examination date of the medical evaluation was May 2013, yet the physician noted the completion date and his signature date as October 2013.
3. The checks and balances used by the administrator and med manager missed the older examination date of the medical evaluation. The facility management has never seen a case where a physician completed a medical evaluation without a recent, current examination.
4. To fix this problem right away, the administrator and med manager quickly performed the following:
    a. A complete audit of all medical evaluations was completed to ensure that no other discrepancy existed;
    b. The worksheet template was enhanced to include the close examination of all dates provided by the physician.
5. To prevent future violations, the facility management team has enhanced the rules for the processing of new admissions, because this incident was the result of an initial screening error. Once the proper information is added to the resident database, the resultant processing is accurate. The administrator and med manager will review, cross-check and sign-off on all medical evaluations prior to it being databased and charted.
6. The administrator and med manager will be individually and collectively responsible to ensure the accurate information and on-going processing of the residents' medical evaluations.

Signature of Legal Entity Representative: Sylvia Brady

Print Name and Title of Legal Entity Representative: J Brady Asst Date: 10-4-13

Anne Grayson 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.182(a) - A home may provide medication administration services for a resident who is assessed to need medication administration services in accordance with § 2600.181 (relating to self-administration) and for a resident who chooses not to self-administer medications. If a home does not provide medication administration services, the resident shall be referred to an appropriate assessment agency.

2a. DESCRIPTION OF VIOLATION

Direct Care staff member " C " completed their initial medication administration course on 8/4/12. The home did not have a record that they maintained the required quartely MAR reviews and practium observations during the year. Direct care staff person "C' would have been due for their annual recertified by 8/4/13.

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.

See Next Page

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J. Brady Owner — **Date** 10-4-13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.182a,b are important to ensure that the facility has properly trained staff to provide medication administration
2. This regulation was violated because the trainer, [redacted] failed to record the fourth quarterly review of staff member C administering medications on 7-11-2013. The facility did have a record of the quarterly reviews performed by [redacted] on 11-29-12, 2-25-13, 5-17-13 (see ATTACHMENT C), however, the 7-11-2013 review was not documented and signed by the trainer.
3. The paid trainer failed to complete her proper documentation of the fourth quarterly review of staff member C. Additionally, this lack of documentation was not caught by the administrator or personnel manager upon their monthly reviews.
4. To fix this problem right away, the administrator and personnel manager quickly performed the following:
    a. A complete audit of all medical administrators (med-techs) was completed to ensure that no other discrepancy existed;
    b. The trainer, [redacted] called in immediately to re-train staff member C.
    c. ATTACHMENT D reflects the re-issuing the "Initial Training by [redacted]
    d. ATTACHMENT E is the invoice from [redacted] detailing her corrective action.
5. To prevent future violations, the facility management team has established the following plan:
    a. The administrator and personnel manager have a cross-check worksheet detailing the initial and progressive training of all the med-techs to supplement [redacted] book and records;
    b. The facility has contracted an IT vendor to program a training database with the advance notices of upcoming training requirements.
6. The administrator and personnel manager will be individually and collectively responsible to ensure the accurate training information and database is maintained to prevent future violations.

Signature of Legal Entity Representative: Jolene Brezdy

Print Name and Title of Legal Entity Representative: J. Brezdy Owner Date: 10-4-13

Anne Glazier 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

2a. DESCRIPTION OF VIOLATION

On the date of inspection Staff person " D " Med Tech. was observed completing and documenting their narcotic count prior to the 3:00pm afternoon Med. Tech had arrived for shift changes. The home's practice is for the oncoming and exiting Med Tech to complete the narcotic count and documtation together.

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J. Brady Dir Date 10-4-13

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

The above plan of correction is approved as of 11-13-13 (Date)

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

Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.185a is very important to ensure the proper storage, access, distribution and use of medications by trained staff persons. The facility has created procedures to enhance the requirements of this regulation and raise the bar of compliance to it.
2. This regulation was violated because staff person D failed to follow company policy and direct supervisory instructions regarding the process of counting narcotics and documenting from one shift to another.
3. The violation was caused by the med-tech counting her narcotics in her med cart and signing the Shift to Shift Narcotic Count prior to the arrival of the incoming shift med-tech. As a matter of record, the incoming med-tech confirmed the count with staff person D and signed it in her presence.
4. To fix this problem right away, the administrator quickly acted in the following manner:
    a. Staff member D was removed from her medication administration position;
    b. Staff member D was given a written warning for failing to follow company policy and a direct supervisory instruction;
    c. All med-techs were re-covered on the proper procedures required by the facility regarding the execution of the Shift to Shift Narcotic Count.
5. To prevent future violations, the facility management team has established the following plan:
    a. The administrator and med manager have re-organized the medication administration coverage to achieve a higher profile of manager audits and cross-checks including the shift changes.
    b. Another manager has been scheduled to oversee the 1st to 2nd shift narcotic counts as well.
    c. The 3rd shift to 1st shift narcotics counts will be administered by the administrator and med manager.,
6. The administrator, med manager and resident care manager will be responsible to ensure the proper procedures are followed in the important area of medication administration.

Signature of Legal Entity Representative: Jean Brady

Print Name and Title of Legal Entity Representative: J. Brady ad Date: 10-4-13

Anne Hayes 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

1. REGULATION 55 Pa.Code §2600

2600.190(a) - A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

2a. DESCRIPTION OF VIOLATION

The Home's Med. Techs reported administering medications that they were not trained to administer.
1. Resident # 3 is prescribed Procrit 3000U to be given subcutaneously 3 times a week Mon. –Wed. -Fri. DX: Anemia
2. Resident # 4 is prescribed Procrit 3000U to be given subcutaneously 3 times a week. Mon- Wed -Fri. DX: Anemia

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) J. Bready Dir Date 10-4-13

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

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

Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.190a is important to ensure the properly trained and licensed medical person is administering injections to the residents. Med-techs trained in diabetic insulin injections may only do those and no other injections.
2. This regulation was violated because the facility's med-techs are not trained to administer Procrit given subcutaneously to two residents.
3. The violation was caused by the misunderstanding of the administrator that the training for diabetic insulin injections covered the Procrit administration. Thus, the med-techs were performing the administering of Procrit.
4. To fix this problem right away,
    a. the physicians for residents 3 and 4 were requested to issue new orders for home care RN's to visit the residents and administer the Procrit (see ATTACHMENT F).
    b. all med-techs were covered that they were not licensed to administer Procrit;
    c. ATTACHMENT G displays the new doctor's orders ;
    d. ATTACHMENT H enlisted Patient Care with new doctor's orders for administering the Procrit.
5. To prevent future violations, the administrator has established a complete review process of all new medications. The administrator and med manager will personally sign off on any extraordinary med that might fall out of the realm of the training of the facility's med-techs.
6. The administrator and med manager will be responsible for the continued compliance to this regulation. The med-techs that have received their diabetic training will solely administer the insulin and not be involved with any other applications.

Signature of Legal Entity Representative: Jeanne Brady

Print Name and Title of Legal Entity Representative : J Brady Dir Date: 10-4-13

Anne Glazier 11-13-13

Violation Report: 20576 - 09/05/2013 - OHaire, Anne
PCH Name: THE VILLA ST ELIZABETH

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

Resident # 5 received an order to self-administer their medication of Nitrostat 0.4mg; the Resident Assessment Support Plan dated 4/25/2013 does not indicate the resident ability to self-administer medications.

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.

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

Signature of Legal Entity Representative
(Required on EVERY Page)

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

Date

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

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Plan of correction implementation status as of 11-13-13 (Date)

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

1. Regulation 2600.227d is important to ensure that each resident's needs are met as those needs change. Additionally, the regulation insists on the facility's accountability to maintain these changes.
2. This regulation was violated because resident 5's assessment and support plan was not updated in a timely manner to reflect her doctor had issued an order for her to self-medicate.
3. The violation was caused by the failure of the facility to update the resident's Assessment – Medications section of the RASP. The RASR had been updated last in April 2013, and it did not reflect the May 2013 physician's order authorizing the resident to self-medicate.
4. To fix this problem right away, the administrator added the necessary information to the resident's RASP while the inspectors were still at the facility on the day of the inspection (see ATTACHMENT I).
5. To prevent future violations, the administrator has moved the resident charts and the med manager into a new office with her. Additionally, the med room fax lines and extensions have been moved into the new office. This new arrangement will prevent any breakdowns of matching medication changes and doctor orders updates to the RASP of each resident.
6. The administrator and med manager will be responsible for ensuring all medication and or doctor order changes are quickly and properly documented in the RASP of each resident.

Signature of Legal Entity Representative: Steven Brandy

Print Name and Title of Legal Entity Representative : Date:

Anne Grayson 11-13-13