



pennsylvania
DEPARTMENT OF PUBLIC WELFARE

FEB 0 4 2014

Ms. Terry O'Connell, NHA
Philadelphia Presbytery Homes, Inc.
2002 Joshua Road
Lafayette Hill, Pennsylvania 19444

RE: Spring Mill Presbyterian Village
License #: 127920

Ms. O'Connell:

As a result of the Department of Public Welfare's licensing inspection on October 16, 2013 and October 17, 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.

Your regular license for the period December 15, 2013 to December 15, 2014 was issued on September 5, 2013. Your regular license remains in good standing.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew J. Jones", with a long horizontal flourish extending to the right.

Matthew J. Jones
Acting Director

Enclosure
License Inspection Summary

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimbell
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 55 Pa. Code §2800
 2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10226.701 - 10226.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION
 On 10/8/13, an allegation of abuse against resident #1 was reported to staff person A. The home did not report until 10/16/13 the allegation to the local area agency on aging or the State Department of Aging.

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.

Preparation and/or execution of the Plan of Correction do not constitute admission by the providers of the truth of the facts alleged, or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared solely as a matter of compliance with state law.

In regards to above incident: Investigation was conducted, initial report submitted to DPW, and resident immediately sent for medical examination upon initial report. This was all completed although resident recanted her allegation. This was supported by the fact that each interview conducted revealed vastly differing accounts of any type of incident. Medical exam revealed no signs of abuse/ harm. Investigation completed with conclusion that abuse did not occur.

Plan of Correction:
 * Administrator, Director of Resident Services, Resident Services Manager, and Memory Support Coordinator all re-educated on Abuse reporting and investigation Requirements using page 182 from Regulatory Compliance Guide. (Exhibit A)
 * Page 182 from Regulatory Compliance Guide added to the DPW reportable clipboard in the community for staff to refer to when completing reports
 * Director of Resident Services / Designee to monitor process for compliance with each abuse investigation and will report findings monthly through quality management

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *C. Livingston*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *CARISA LIVINGSTON LPN/PCA* Date *12-20-13*

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

The above plan of correction is approved as of <u>1/8/14</u> (Date)	Plan of correction implementation status as of <u>1/8/14</u> (Date)
The above plan of correction was approved by <u>CLM</u> (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

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 65 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
 -On 10/17/13, at 10:15am, all resident records for Cedar Grove residents were unlocked and accessible in the cabinet of the kitchenette island.
 -On 10/17/13, at 4:20pm, the resident support plan binder was unlocked and accessible on the counter of the Secure Dementia Unit nurses station.

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.

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- Plan of Correction
- * Cedar Grove staff re-educated on regulation 2600.17 regarding record confidentiality and access on or before 12/20/13. (Exhibit B)
 - * Lock installed in the cabinet of the kitchenette island for Cedar Grove on 12/18/13. Support Plan binder will also be stored in this location. Direct Care Staff have a key to this area. (exhibit C)
 - * Memory Support Coordinator / Designee will conduct random audits to ensure compliance and will report findings through monthly Quality Management

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *C Livingston*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Cancer Livingston LPN/PCA* Date *12.20.13*

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The above plan of correction was approved by <u><i>DLM</i></u> (Initials)	<input checked="" type="checkbox"/> Fully Implemented <input type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 56 Pa.Code §2600
 2600.96(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

2a. DESCRIPTION OF VIOLATION
 The first aid kit in the Secure Care Dementia Unit does not include tweezers.

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.

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Tweezers added to the first aid kit for the Secured Dementia Unit during the inspection.

* Memo posted to remind staff to replace items taken from emergency kit or inform supervisor of need for replacement when used (Exhibit D)

* added to safety committee monthly audit to ensure contents of first aid kits

* Memory Support Coordinator / Designee will monitor process and will report findings through monthly Quality Management

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

Signature of Legal Entity Representative (Required on EVERY Page) *C Livingston*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *CANSEL LIVINGSTON LPN/PCA* Date *12.20.13*

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 (Date)

Plan of correction implementation status as of 1/8/14
 (Date)

The above plan of correction was approved by *CL*
 (Initials)

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

Violation Report: 12792 + 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 56 Pa.Code §2600
 2600.103(g) - Food shall be stored in closed or sealed containers.

2a. DESCRIPTION OF VIOLATION
 -The 8 large ice cream containers in the freezer located outside of the kitchen entrance were opened and unsealed.
 -The oreo cookies in the dry goods storage area had a hole in the package and was opened and unsealed.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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- * Ice cream containers and oreo cookies discarded during inspection
- * Dining Services Staff re-educated in regards to regulation 103 g proper food storage (exhibit E)
- * Weekly audits of freezer outside of the kitchen entrance and dry goods storage area to be conducted by Director of Dining Services / designee to ensure compliance with closed/ sealed containers
- * Director of Dining Services / designee to report findings through monthly quality management

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

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Carissa Livingston LPN/PCA* Date *12-20-13*

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 (Date)

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 (Date)

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

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

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberil
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 55 Pa. Code §2000
 2600.107(d) - The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

2a. DESCRIPTION OF VIOLATION
 The home's written emergency procedures have not been submitted to the municipal emergency management agency in 2012.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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- * Letter forwarded from the Office of the Fire Marshall to acknowledge receipt and review of the Emergency Preparedness plan dated May 6, 2012. (exhibit F)
- * Also have 2013 letter on file as well.
- Director of Environmental Services to continue to send Emergency Preparedness Plan to emergency management agency annually in May
- Will be added to May agenda for quality Management review to ensure receipt is obtained

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

(Livingston)

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

Carisa Livingston LPN/PCA

Date: *12.20.13*

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1/8/14
 (Date)

Plan of correction implementation status as of

1/8/14
 (Date)

The above plan of correction was approved by

CPN
 (Initials)

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

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 55 Pa. Code §2600
 2600.141(a)(1) - A resident shall have a medical evaluation by a physician, physician's assistant, or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

2a. DESCRIPTION OF VIOLATION
 Resident #2 was admitted on 12/28/12. The resident's medical evaluation was completed on 5/23/13.

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.

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- * Resident Services Manager re-educated on regulation 141 (a) (1) in regards to acceptable time frames for Documentation of Medical Evaluation (Exhibit A)
- * resident records review for compliance with 141 (a) (1) completed on 12/18/13
- * Director of Resident Services/ designee to review new resident records within 30 days of admission to ensure DME is obtained in acceptable time frame and will report findings through monthly Quality Management

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *C Livingston*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Carisa Livingston LPA/RCA* Date *12.20.13*

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Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberl
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 65 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
 The home did not implement procedures for the safe use and access of medications. On 10/17/13 resident #3 had an order for Systane Ophthalmic Solution eye drops as needed. This medication was not available in the home.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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The Systane eye drops were obtained during the inspection and are available for as needed use.

- * Review completed to ensure availability of Resident's as needed medications 12/20/2013
- * Pharmacy sending monthly as needed medication reports beginning December 18th 2013. Reports will be used to audit medication supply to ensure compliance.
- * Memory Support Coordinator / Resident Services Manager/ designee to direct this process. Director of Resident Services / Designee to monitor compliance and report audit findings monthly through Quality Management

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) *CARISA LIVINGSTON LPN/PCA* Date *12-20-13*

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The above plan of correction is approved as of 1/8/14 (Date)

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

Plan of correction implementation status as of 1/8/14 (Date)

Fully implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 56 Pa.Code §2600
 2600.226(o) - The administrator shall notify the Department's personal care home regional office within 30 days after a resident with mobility needs is admitted to the home or the date when a resident develops mobility needs.

2a. DESCRIPTION OF VIOLATION
 On 10/16/13, the Department requested a list of residents with mobility needs. This list did not contain residents #4 and #5 who have mobility 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.

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- * Review of resident records completed 12/18/13 to ensure accurate list of residents with mobility needs.
- * Director of Resident Services / Designee to maintain list and inquire of any mobility changes daily M-F during Interdisciplinary Team Meeting
- * Director of Resident Services / Designee to audit records at random for accuracy and report findings monthly through Quality Management

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *C Livingston*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Carisa Livingston LPN/PCA* Date *12.20.13*

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 (Date)

Plan of correction implementation status as of 1/8/14
 (Date)

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

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

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 55 Pa.Code §2600
 2600.227(c) - The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION

As of March 2013 resident #2 was assessed to require a companion. The support plan was not revised to indicate the services provided by the companion or when the companion is in the home to provide these services. Staff interviewed indicated the companion is in the home 16 hours per day and the nursing notes stated that the companion is there 12 hours per day. Without this indicated staff have no way of knowing what times and what services they are required to perform.

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

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- * Resident #2 RASP updated at time of inspection to reflect most current hours/services of companion
- * Review of RASP completed 12/19/2013 for residents receiving companion services to ensure accuracy / up to date information in regards to services and hours being provided by companions
- * Resident Services Manager, Director of Resident Services, Memory Support Coordinator re-educated on regulation 2600.227 (c) (exhibit A)
- * Director of Resident Services / Designee to review RASP of residents receiving companion services monthly to verify accuracy and report findings through monthly Quality Management Process

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

Signature of Legal Entity Representative
 (Required on EVERY Page) *C. Livingston*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *CAROL LIVINGSTON LPN/PCA* Date *12-20-13*

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The above plan of correction was approved by <u>DRLW</u> (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

Violation Report: 12792 - 10/16/2013 - Foukes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

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

-The assessment dated 1/2/13 for resident #2 indicates that the resident is currently receiving in house PT/OT. The resident was not continuously receiving PT/OT from 1/2/13 to 10/17/13. The resident had orders dated 1/3/13 for physical therapy, 3/4/13 for a PT/OT evaluation and treatment, 6/13/13 for an OT evaluation due to a malfunctioning wheelchair, 7/11/13 for PT to evaluate and treat, and 9/12/13 for PT to reevaluate for leg weakness and ambulatory dysfunction. The resident's support plan was not updated to indicate these changes and how these needs will be met.

-Resident #2 required skilled nursing for a shin wound from 3/8/13 through 4/12/13 and had an order dated 6/7/13 for skilled nursing for wound care bilateral arms. The resident's support plan was not updated to indicate these changes and how these needs will be met.

-Resident #2 had a physician's order dated 7/11/13 for speech therapy and dysphagia evaluation. The resident was seen on 7/22/13 and given an order to have speech therapy two times per week times two weeks to improve swallowing and decrease risk of aspiration. The resident's support plan was not updated to indicate these changes and how these needs will be met.

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.

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- * Resident #2 record has been updated
- * Record review to ensure current outside referral information up to date in RASPs completed 12/20/2013
- * BI-weekly IDT meeting to be held to ensure records are up to date with current outside referred services and frequencies beginning 12/20/2013
- * Memory Support Coordinator / Resident Services Manager to audit records for compliance and Director of Resident Services / designee to report findings at monthly quality Management

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

C. Livingston

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

Carsa Livingston LPN/PCA

Date *12-20-13*

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The above plan of correction is approved as of

1/8/14
(Date)

Plan of correction implementation status as of

1/8/14
(Date)

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

The above plan of correction was approved by

CLM
(Initials)

Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 65 Pa.Code §2600
 2600.231(c) - A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION

Resident #6 was admitted to the SDU on 6/10/13. The resident had a preadmission screening on 6/3/13.

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.

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- * Memory Support Coordinator re-educated on regulation 2600.231 (a) (Exhibit A)
- * Resident Records reviewed on 12/19/2013 for compliance with pre-screen acceptable time frame for secured dementia unit admissions
- * Director of Resident Services to audit new admission pre-screens for compliance and report findings through monthly Quality Management

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) *Carisa Livingston LPN/PCA* Date *12.20.13*

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Violation Report: 12792 - 10/16/2013 - Foulkes, Kimberli
 PCH Name: SPRING MILL PRESBYTERIAN VILLAGE

1. REGULATION 65 Pa.Code §2600
 2600.234(a) - Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

2a. DESCRIPTION OF VIOLATION
 Resident #5 was admitted to the SDCU on 7/14/13. The resident's initial support plan was developed on 6/28/13.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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Resident #5 was admitted to the Secured Dementia Unit on 6/14/2013 under a respite stay agreement. The RASP was completed as a best practice so the team would know the plan of care for resident #5. On 7/14/2013 the resident was signed on as a permanent resident therefore changing the admission date. Resident #5's plan of care, living arrangement were not changed by this contractual change and therefore a new RASP was not needed. At the time of inspection, the original respite RASP was still a true representation of the resident needs and plan to support.

This process was completed based on the following guidelines listed on page 219 of the regulatory compliance guide relating to the "RASP and SDCU's" #2 (inserted below for review.)

(2. Complete only the support plan portion of the RASP within 72 hours prior to or after admission to a SDCU, complete the assessment portion of the RASP within 15 days of admission to the SDCU, and finalize the support plan within 30 days of admission to the SDCU. Excluding any significant changes that would require a new assessment (see § 2600.225(b)(2)), a new RASP would not need to be completed until one year following the completion of the finalized support plan.)

Considering this regulatory guidance listed above, I am respectfully requesting your withdrawal of this violation.

Director or Resident Services / designee ensure that respite RASP's are updated if/when a short term resident decides to stay long-term if needed. Changes in contract are reviewed monthly through quality management.

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

Signature of Legal Entity Representative (Required on EVERY Page): *[Handwritten Signature]*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): *CAROL LIVINGSTON LPN/PCA* Date: *10-20-13*

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