



**pennsylvania**  
DEPARTMENT OF PUBLIC WELFARE

Sent via email to: [REDACTED]

MAILING DATE: December 1, 2014

Thomas and Diane Fulmer  
333 Ertel Road  
Williamsport, Pennsylvania 17701

RE: Fulmers Personal Care Home  
201 Woodward Avenue  
Lock Haven, Pennsylvania 17745  
License # 347360

Dear Mr. and Mrs. Fulmer:

As a result of the Department of Public Welfare's licensing inspection on November 3, 2014 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.

Sincerely,

Michele Moskalczyk  
Regional Licensing Administrator

Enclosure  
Licensing Inspection Summary



Violation Report: 34736 - 11/03/2014 - Yellenic, Cindy  
 PCH Name: FULMERS PERSONAL CARE HOME

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 10-29-14, Resident #1 cut in line in front of Resident #2 at the home's Halloween party. Resident #2 told Resident #1 to go to the back of the line, so Resident #1 slapped the back of Resident #2's head. Resident #2 replied, "I don't have to take this", so Resident #1 hit Resident #2 in the face and pushed the resident causing the resident to lose their balance and fall to the floor, resulting in a facial contusion and a facial laceration.

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.

Immediately following the incident the police were called to either start the process to have resident #1 evaluated for a 302 or voluntary admission to a mental hospital. Resident #1 agreed to voluntarily check himself into a mental hospital. 8 mental health hospitals denied him because of either, his oxygen needs, his insurance or no availability. The hospital called [redacted] and pressured him to take resident #1 back. He returned to the PCH at 4am the next morning.

Both resident #1 and #2 were questioned about the incident. Resident #2 was questioned about whether she felt safe in the home. A plan was put in place to keep these residents separated as much as possible. Staff was informed of this plan.

The psychiatrist and PCP were contacted about the incident. Resident #1 saw his PCP on 10/31 and some medications were adjusted. Resident #1's family was notified. The Local AAA and Harrisburg AAA were notified and appropriate reporting was done.

Resident #1 had already been given a 30 Day Notice following another incident on 10/19. His MH/ID caseworker was made aware of this second incident as well and he gave us an update on attempting to relocate resident #1.

The RASP for resident #1 was updated with a significant change. DCS staff were instructed to monitor resident #1 with documented routine checks.

There have been no other incidents or aggressive behaviors noted since; the staff is still doing 30 minute checks on him. His caseworker is still looking for another home for him.

De-escalating volatile situations is a training topic that has been and will be covered throughout our training year at various times. We will be covering this topic again at our December meeting. This topic will also be discussed in resident council meetings where we can attempt to make it clear to the residents what behaviors are unacceptable in the home and that this behavior is not tolerated. Dealing with this issue at resident councils will also help to give us a heads up on any potentially volatile situations before they

*The Administrator shall assure that ALL residents are not neglected, intimidated, physically or verbally abused, mistreated in any way. The Administrator shall be responsible for ongoing*

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

*Shall be responsible for ongoing*

Signature of Legal Entity Representative  
 (Required on EVERY Page)

*[Signature] Compliance M 12/1/14*

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

*April Fulmer*

Date

*11/25/14*

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The above plan of correction is approved as of 12/1/14  
 (Date)

Plan of correction implementation status as of 12/1/14  
 (Date)

The above plan of correction was approved by

*[Signature]*  
 (Initials)

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

Violation Report: 34736 - 11/03/2014 - Yellenic, Cindy  
 PCH Name: FULMERS PERSONAL CARE HOME

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  
 Resident #1 had an incident on 10-19-14 involving hitting a staff person in the head, the home did not put into place a monitoring checks system for Resident #1 to identify or defuse potential situations, and to modify or eliminate a behavior that endangers the resident or others. The home did not address the incident on 10-19-14 until after an incident on 10-29-14, when Resident #1 physically assaulted Resident #2 during the home's Halloween Party.

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.

225(c)-

Following the incident on 10/19/14 staff were made aware to monitor resident #1 for further aggressive behaviors. An addendum was added to his RASP which specifically talked about how to de-escalate the situation if a similar one occurred. An example would be having resident #1 make a phone call to a family member when he gets frustrated to calm him down. His caseworker, PCP and psychiatrist were notified of the incident and a 30 Day Notice was given. His family was also informed. This was all detailed in the addendum to his RASP which was updated on 10/20/14, the day after the incident. See copy of the addendum from 10/20/14.

*The administrator shall monitor and assure ongoing compliance.*  
*M*  
*10/1/14*

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) *April Fulmer, Administrator*      Date *11/25/14*

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

The above plan of correction is approved as of <u>12/1/14</u> (Date)	Plan of correction implementation status as of <u>12/1/14</u> (Date)
The above plan of correction was approved by <u>M</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