



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: January 27, 2016

Mr. John Williams, President
Maple Valley personal Care Home, Inc.
2212 Anthony Run Road
Indiana, Pennsylvania 15701.

RE: Maple Valley Personal Care Home
Certificate/License #427690

Dear Mr. Williams:

As a result of the Department of Human Services' licensing inspection on September 8, 2015, 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,

A handwritten signature in black ink that reads "John Kimberland" with a stylized flourish at the end.

John Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 42769 - 09/08/2015 - McConnell, Deb
PCH Name: MAPLE VALLEY PERSONAL CARE HOME

JAN 21 2016

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.

WEST REGION FIELD OFFICE
Human Services Licensing

2a. DESCRIPTION OF VIOLATION

Resident #1's assessment, dated 9/16/14, was not updated to address the resident's increased confusion, unsteady gait, and poor balance identified by the home on 6/13/15.

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 ENCLOSED UPDATED SUPPORT PLAN. STAFF WHO WRITES SUPPORT PLANS HAS BEEN EDUCATED AS TO THIS REQUIREMENT.

Within 30 days of receipt of the accepted plan of correction: The administrator or designee shall develop and implement a system to ensure all resident assessments are immediately updated as resident care needs change. All direct care staff shall be educated on the new system. Documentation of education will be kept. *1-22-16*

Within 30 days of receipt of the accepted plan of correction: All staff persons completing assessments will be educated regarding the completion and accuracy of assessments. Documentation of education will be kept. *1-22-16*

Within 30 days of receipt of the accepted plan of correction: The administrator or designee will review all current resident assessments for accuracy and completion to ensure all resident diagnoses are included in each resident's assessment. *1-22-16*

Repeat Violation: Yes	Date(s) of Previous Violation(s):	03/10/2015
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Signature of Legal Entity Representative
(Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>JOHN WILLIAMS</i>	<i>1-14-16</i>

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

The above plan of correction is approved as of <u>1-22-16</u> (Date)	Plan of correction implementation status as of <u>1-22-16</u> (Date)
The above plan of correction was approved by <u><i>S</i></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

JAN 21 2016

Violation Report: 42769 - 09/08/2015 - McConnell, Deb
PCH Name: MAPLE VALLEY PERSONAL CARE HOME

WEST REGION FIELD OFFICE
Human Services Licensing

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 #1's support plan, dated 9/30/14, does not indicate the resident's required use of a bed/chair alarm and 2 hour monitoring due to the resident's non-compliance of assisted transfers and ambulation. The resident's support plan does not indicate the care and services the home will provide related the resident's diagnoses of anxiety, dementia, depression or the need for assistance in feeding and drinking due to loss of range of motion and inability to raise the silverware/glass to the resident's mouth.

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 ENCLOSED UPDATED SUPPORT PLAN

Within 30 days of receipt of the accepted plan of correction: The administrator or designee shall develop and implement a system to ensure all resident support plans are immediately updated as resident care needs change. All direct care staff shall be educated on the new system. Documentation of education shall be kept in the staff record. *1-22-16 g*

Within 30 days of receipt of the accepted plan of correction: All staff persons completing support plans will be educated regarding the completion and accuracy of support plans including the care and services the home will provide. Documentation of education shall be kept in the staff record. *1-22-16 g*

Within 30 days of receipt of the accepted plan of correction: The administrator or designee will review all current completed support plans for accuracy and completion including the care and services the home and any other agency will provide. *1-22-16 g*

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *John Williams, Administrator* Date *1-14-16*

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