



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [REDACTED]
Mailing Date: September 14, 2016

Ms. Annette Chickey, Administrator
UMH PA Corp
209 Roberts Road
Pittston, Pennsylvania 18640

RE: Wesley Village
215 Roberts Road
Pittston, Pennsylvania 18640
License # 241880

Dear Ms. Chickey:

As a result of the Department of Human Services' licensing inspection on July 28, 2016 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
Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 24188 - 07/28/2016 - Foulkes, Kimberli
 PCH Name: WESLEY VILLAGE

1. REGULATION 55 Pa.Code §2600
 2600.42(c) - A resident shall be treated with dignity and respect.

2a. DESCRIPTION OF VIOLATION
 On 7/13/16 at approximately 9 am staff person A went into resident #1's room and found the bed sheets covered with a bed protector over fecal soiled sheets. The resident stated to staff person A that they had an accident last night and staff person B told them they should inform the day shift to "change his/her sheets in the morning". The resident had slept in a bed with fecal soiled sheets, covered by the bed protector, which had an offensive odor through the night.

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.

Attachment # 1

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Sharon Ritsick RN/PC Administrator* Date *9/8/2016*

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

The above plan of correction is approved as of <u>9/13/16</u> (Date) The above plan of correction was approved by <u><i>M</i></u> (Initials)	Plan of correction implementation status as of <u>9/13/16</u> (Date) <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
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Searon Rutick RN/PC Admin.
9-8-16

Regulation 2600.42(c):

Attachment # 1

Plan of Correction:

The Administrator was made aware of the incident which occurred with this resident, on the morning of 7/13/2016, by a dayshift employee whom the resident initially reported the incident.

The Administrator began an investigation of the incident immediately. The Administrator interviewed the staff who reported the incident to her, and the resident involved, who was asked to write a statement of the events. The Administrator assisted the resident in writing the statement of events which occurred, due to the resident having some limitations with her writing skills.

The Administrator notified the residents' responsible party of the situation which occurred, and was informed that an investigation was in the progress, and notification would occur upon final resolution of the investigation. The Administrator also informed the residents' responsible party that this alleged lack of care, would not be tolerated in the facility, and the staff negligent of providing adequate care to the resident would be appropriately disciplined.

Reportable incident was submitted to the Department on 7/13/2016, by the Administrator.

The employee involved was scheduled to work the night shift, 12am-8am, on July 13, 2016. The Administrator notified the employee of the investigation, and suspended the employee for her scheduled shift on 7/13/2016, pending further investigation of the incident. The employee was scheduled to meet with the Administrator and the Human Resource Director, and obtain her statement of the incident.

Mandatory Abuse report was completed and forwarded to the area Agency on Aging on 7/14/2016, per the proper required protocol.

The employee met with the Administrator and the Director of Human Resources as scheduled on 7/14/2016. Upon conclusion of the meeting with the employee, and the information compiled from the resident involved, and other staff, it was concluded that the employee willfully neglected the needs of a resident which had been assigned to her care.

M
9/13/16
Cont. →

Searon Pitsch RN/PC Admin.
9-8-16

The employee was terminated from her position as a Personal Care Attendant, at the Wesley Village Personal Care facility, on 7/14/2016.

The employer had filed the Mandatory Abuse form to the area Agency on Aging as stated previously.

The residents' responsible party was notified of the resolution of the investigation and the termination of the employee involved.

The Administrator will be responsible to assure that all residents are treated with the dignity and respect they deserve, and provided with what is expected from the facility which they have placed their trust in, and provided with the care to which they have been promised by the facility staff and management.

The staff are educated on Resident Rights upon their initial hiring into the facility. A review of the Resident Rights are also a part of the annual in-service, which all employees are required to attend to maintain their annual education hours for employment.

The Administrator maintains an open-door policy for all residents, which provides an environment which makes the resident feel comfortable to approach the Administrator at any time, with any concerns or problems which they may encounter with the facility and/or staff.

Resident House meetings are scheduled monthly with the residents to meet as a group to discuss any problem or concerns. Residents which may not feel comfortable discussing "staff issues" in a group, are encouraged to do so in private with the Administrator.


9/13/16