pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to:
MAILING DATE: January 5, 2017

Ms. Cynthia Mazza, VP/COO
Salisbury Behavioral Health Inc.
3894 Courtney Street, Suite 100
Bethlehem, Pennsylvania 18017

RE: Salisbury Behavioral Health PCH of Monroe County
1482 Cherry Lane
East Stroudsburg, Pennsylvania 18301
License #: 212130

Dear Ms. Mazza:

As a result of the Department of Human Services' licensing inspection on November 17, 2016 and December 15, 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
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: SALISBURY BEHAVIORAL HEALTH PCH OF MONROE COUNTY	**License Number:** 21213
Address: 1482 CHERRY LANE, EAST STROUDSBURG, PA 18301	**County:** Monroe
Administrator: Kristena Allen	**Region:** NORTHEAST

Legal Entity Name: SALISBURY BEHAVIORAL HEALTH INC

Legal Entity Address: 3894 COURTNEY STREET SUITE 160, BETHLEHEM, PA 18017

Certificate(s) of Occupancy

C-2 LP
07/26/2008
Dept. of Labor & Industry

Staffing Hours

Resident Support: NM	**Total Daily Staff:** 17	**Waking Staff:** 13
Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

11/17/2016: Rushin, Julienne
12/15/2016: Rushin, Julienne

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: 28

Number of Residents Served: 17

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: 0

Number of Hospice Residents in past year: 0

Number of Residents who:

- **Receive Supplemental Security Income:** 17
- **Are 60 Years of Age or Older:** 5
- **Have Mental Illness:** 17
- **Have an Intellectual Disablility:** 0
- **Have a Mobility Need:** 0
- **Have a Physical Disability:** 0

Violation Report: 21213 - 11/17/2016 - Rushin, Julienne
PCH Name: SALISBURY BEHAVIORAL HEALTH PCH OF MONROE COUNTY

1. REGULATION 55 Pa.Code §2600
2600.23(a) - A home shall provide each resident with assistance with activities of daily living as indicated in the resident's assessment and support plan.

2a. DESCRIPTION OF VIOLATION
Based on information obtained from staff interviews, it was determined that on 12/05/16, resident #1's Wanderguard sounded as he/she walked out on to the back deck of the home. Staff person "A" deactivated the Wanderguard alarm so resident #1 could sit outside. Staff person "A" then went downstairs to the kitchen area and left resident #1 unattended. Resident #1 then walked around to the front of the building and down the road when a passerby noticed him/her an alerted staff. The home failed to provide resident #1 with the "extensive level of supervision" as indicated in ███ RASP by deactivating the Wanderguard and leaving him/her unsupervised.

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.

Regulation 2600.23 explains the importance of providing the necessary level of assistance a resident requires as outlined in their RASP. This regulation was violated when staff person "A" did not remain within eyesight of the resident after disarming ███ Wanderguard device, which then allowed the resident to wander from the facility grounds. This caused a lapse in the extensive level of supervision the resident required as outlined in ███ RASP.

Immediately and on going, staff will remain within eyesight of a resident that has been identified as needing extensive supervision whenever they are outside on the grounds of the facility or in the community. Additionally, the administrator will be responsible for creating a monitoring plan for the resident, as well as ensuring the compliance of the above noted regulation and plans.

The administrator shall monitor and assure ongoing compliance.
[signature] 12/30/16

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) Kristena Allen Administrator — **Date** 12-25-16

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

The above plan of correction is approved as of 12/30/16 (Date)

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

Plan of correction implementation status as of 12/30/16 (Date)

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