



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: September 26, 2017

Ms. Loriann Putzier,
President & COO
VS Woods LLC
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: The Woods at Cedar Run
824 Lisburn Road
Camp Hill, Pennsylvania 17011
Certificate #: 331320

Dear Ms. Putzier:

As a result of the Department of Human Services' licensing inspection on April 20, 2017 and August 30, 2017 of the above facility, a violation with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary was found.

The violation 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,

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 33132 - 04/20/2017 - Rosenblat, Dale
 PCH Name: THE WOODS AT CEDAR RUN

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

Resident #1, admitted [redacted] 14, required total assistance in toileting and a 2-person assist in ambulation as documented in the 3/1/17 Resident Assessment and Support Plan (RASP). On [redacted] 17, at approximately 8:30 pm, Resident #1 was found sitting on the toilet unresponsive by Direct Care Staff Members' A and B. Both staff members, certified in CPR and First-Aid, left Resident #1 alone to seek help. Upon return, Staff Members' A and B found Resident #1 on the floor in the bathroom surrounded by "a pool of blood" from a head wound sustained due to the fall, according to a witness statement by Staff Member A. The investigation report by the Cumberland County Coroner's Office on [redacted] 17, determined the cause of death to be from a subdural hematoma due to a fall on [redacted] 17. Resident #1 was neglected by being left unsupported and alone in the bathroom by Direct Care Staff Members' A and B.

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 Attached. Pages 2A + 2B of 2. -*JE*

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Courtney Bolinsky

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

Courtney Bolinsky, Executive Director

Date *9/22/17*

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

The above plan of correction is approved as of *9-26-17*
 (Date)

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

Plan of correction implementation status as of *9-26-17*
 (Date)

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

Community Name: The Woods at Cedar Run

License Number: 33132

Date of Visit: 04/20/2017

Date of Submission: 08/22/17

1. **Violation Review:** 2600.42 (b) A Resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. 99

2. **Violation Interpretative Statement:** Resident #1, admitted [REDACTED]/2014, required total assistance in toileting and a 2-person assist in ambulation as documented in the 3/01/2017 RASP. On [REDACTED] 2017, at approximately 8:30 p.m., Resident #1 was found sitting on the toilet unresponsive by Direct Care Staff Members A and B. Both staff members, certified in CPR and First-Aid, left Resident #1 alone to seek help. Upon return, Staff Members A and B found Resident #1 on the floor in the bathroom surrounded by "a pool of blood" from a head wound sustained due to the fall, according to a witness statement by staff member A. The investigation report by the Cumberland County Coroner's Office on [REDACTED] 17, designated the cause of death to be from a subdural hematoma due to a fall on [REDACTED] 17. Resident #1 was neglected by being left unsupported and alone in the bathroom by Direct Care Staff Members A and B.

3. **Review the benefit of the Regulation, per RCG:** The primary benefit of the regulation is to protect Residents from abuse and neglect.

4. **Description of the Repair of the Immediate Problem:** Resident #1 was on hospice services, and help was being sought as this situation was not a typical medical emergency given resident's hospice status. When help arrived back in the resident's room and [REDACTED] was found on the floor it was determined to call 911. Emergency service personnel arrived on scene and assumed care from this point. Emergency walkie talkie's were tested and found to be in working order on 4/10/17. On 4/10/17 Emergency call system was tested and found to be in working order. Executive Director met with each shift from 4/10/17 to 4/12/17 to debrief.

5. **Determine / document the Root Cause of the Violation:** Internal investigation revealed the following concomitant factors:
 - The known preference and practice for Resident #1 was to request privacy and extended amount of time for toileting;
 - ~~Resident #1 was on Hospice services, and calling 911 directly would have violated standing protocol with the Hospice and the Resident's RASP; Unacceptable Statement - he~~
 - Simultaneously, EMS had been summoned for a different medical emergency in the building, and this impacted response to the call for equipment to measure vital signs;

Courtney Bolif 8/22/17

- A one-to-one staffing pattern for Residents during medical emergencies had not been firmly established by way of written policy or training for DCS.

JE

6. Detail Action Steps / System Developed to prevent future occurrence:

- a. The community re-visited their Emergency Medical Plan: Staffing Plan standards to amend them to reflect the need for at least temporary one-to-one staffing to avoid leaving injured or unresponsive Residents alone or in precarious circumstances where further injury is likely or possible; and the EMP also reinforces the establishment of, training on and use of communication devices and protocols for when Residents are discovered to be injured or should not be left alone.
- b. Training on the updates (staffing and communication) to the Emergency Medical Plan amendments took place on 8/18/17. These factors will also be reinforced during *General Orientation* (on-boarding process) when discussing the Emergency Medical Plan, and the Training Record reflects the review of the Emergency Medical Plan. The Emergency Staffing Pattern and response to various emergencies will be reviewed during the All-Staff Quarterly Meeting Scheduled for 8/18/17, and a record of all training will be maintained.
- c. **On-going Monitoring?** The Director of Resident Care will oversee and evaluate the response to incidents and emergencies daily as a function of her role in reviewing the activities of the department for the previous 24-hours. The review will include follow up review of documentation and (potentially) interview of those responding and of Charge personnel to establish appropriate responses and outcomes during such incidents. A review of the incidents and responses will be conducted with the Executive Director, also daily during the work-week until such time that a pattern of compliance with the plan of correction has been established.

7. Designated position responsible and specify target date for correction: The Administrator is responsible to ensure that the aforementioned training is conducted, completed and documented by 9/15/17.

Authorized Signature  Date: 8/22/17