pennsylvania
DEPARTMENT OF HUMAN SERVICES

AUG 29 2018

Ms. Katherine Hershey
Senior Executive Director
Presbyterian Homes, Inc.
One Trinity Drive, East Suite 201
Dillsburg, Pennsylvania 17019

RE: Steward Place
7 East Locust Street
Oxford, Pennsylvania 19363
License #: 100630

Dear Ms. Hershey:

As a result of the Department's Bureau of Human Services Licensing annual inspection on May 29, 2018 and June 4, 2018 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: STEWARD PLACE	License Number: 10063
Address: 7 EAST LOCUST STREET, OXFORD, PA 19363	County: Chester
Administrator: Tiffanie Small	Region: SOUTHEAST
Legal Entity Name: PRESBYTERIAN HOMES INC	
Legal Entity Address: ONE TRINITY DR EAST SUITE 201, DILLSBURG, PA 17019	

Certificate(s) of Occupancy
C-2 LP
07/11/2005
L&I

Staffing Hours
Resident Support: 0 | Total Daily Staff: 44 | Waking Staff: 33

Type of Inspection: Full | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)
Renewal, Incident

On-Site Inspections Dates and Department Representatives On-Site
06/29/2018: Wooters, Sandra; Chung, Youn Hie
06/04/2018: Wooters, Sandra; Chung, Youn Hie

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: 84

Number of Residents Served: 44

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: 0

Are 60 Years of Age or Older: 44

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 0

Have a Physical Disability: 5

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.65(d) - Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until completion of the following:
(1) Training that includes a demonstration of job duties, followed by supervised practice.
(2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
(3) Initial direct care staff person training to include the following:
(i) Safe management techniques.
(ii) ADLs and IADLs.
(iii) Personal hygiene.
(iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
(v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
(vi) Implementation of the initial assessment, annual assessment and support plan.
(vii) Nutrition, food handling and sanitation.
(viii) Recreation, socialization, community resources, social services and activities in the community.
(ix) Gerontology.
(x) Staff person supervision, if applicable.
(xi) Care and needs of residents with special emphasis on the residents being served in the home.
(xii) Safety management and hazard prevention.
(xiii) Universal precautions.
(xiv) The requirements of this chapter.
(xv) Infection control.
(xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION
Direct care staff person A, hired on 09/06/16, began providing unsupervised ADL services on 09/09/16 before completing the online direct care training course and passing the competency test.

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.

Staff member previously completed the online training prior to unsupervised ADL services; due to certificate not being available at time of inspection a new certification was completed. Updated certification presented to inspector during 6/4/18 inspection (see attachment B) completed 6/1/18 SW
Ongoing:
1. All new hires will complete the online direct care training prior to providing unsupervised ADL services.
2. PCH Administrator will audit new hire training for compliance prior to staff providing unsupervised ADL services prior to 1st day on the job, starting immediately. SW 8/24/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

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

Date 8/9/18

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

The above plan of correction is approved as of 8/24/18 (Date)

The above plan of correction was approved by SW (Initials)

Plan of correction implementation status as of 8/24/18 (Date)

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

Violation Report: 10083 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600

2600.65(f) - Training topics for the annual training for direct care staff persons shall include the following:

(1) Medication self-administration training.
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
(3) Care for residents with dementia and cognitive impairments.
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
(5) Personal care service needs of the resident.
(6) Safe management techniques.
(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff persons B and C did not have medication self-administration training for training year 2017.

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.

Request for reconsideration due to :

Staff members received self-administration training via Relias training modules annually (see attachment C&D; The relias module met the intent of the regulation

Relias module updated to separate the self administration training.
Staff re-trainined on Self-administration on 6/20/18 (see attachment E).

Ongoing:
Staff will be trained annually on topics for direct care staff
PCH Administrator will audit training records annually for completion of all required training topics for direct care staff at least annually, starting within 30 days of receipt of this P.O.C. 8/24/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

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

Date 8/9/18

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- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
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- ☐ Not Implemented

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600

2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
(3) Resident rights.
(4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
(5) Falls and accident prevention.
(6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION

Direct care staff persons A, B, C, and D did not complete resident rights training during the 2017 training year.

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.

Staff received resident rights traning via relias modules (see attachment F, G, H, I); relias module update to include all of the resident rights listed in the 2600 regulation.
Staff re-trained on resident rights on 6/5/18 (see attachment J)

Ongoing:
Staff will be trained annually on topics for direct care staff
PCH Administrator audit training records annually for completion of all required topics for direct care staff

All staff of the home will receive training on the P.C.H. Resident Rights on an annual basis by the administrator or designee, starting immediately. SD 8/24/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tiffanie Small/Adm | Date 8/9/18

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- [ ] Not Implemented

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION
Resident #1 sleeps on a reclining chair (her own choice due to her bed not being comfortable), which is covered with plastic covering (non fire retardant) and is hazardous.

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.

Corrected at the time of inspection
Family notified of hazard and removal of hazard material
Staff in-serviced on hazardous materials and notification to manager.

Ongoing
PCM and RSM will check for hazards monthly during compliance rounds and remove any hazardous materials

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tiffanie Small/RM | Date 8/9/18

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- [x] Fully Implemented
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- [ ] Not Implemented

Violation Report: 10063 - 06/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.103(e) - Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

2a. DESCRIPTION OF VIOLATION
The refrigerator in the main kitchen contained prepared eggs that were not labeled or dated.
The freezer in the main kitchen contained French toast strips in a bag that were not labeled or dated.
The refrigerator/freezer located on the 1st floor common room contained a container of ice cream, neither labeled nor dated.

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.

Dining staff will be in-serviced on labeling and dating of food items by 8/20/18

Ongoing:
Dining manager will be check compliance weekly to ensure all items are dated and labeled correctly

Administrator will conduct periodic inspections of refrigerators/freezers to ensure food is labeled and stored properly @ 8/24/18
Starting immediately.

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

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

Date 8/9/18

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The above plan of correction was approved by 8/24/18 (Initials)

Plan of correction implementation status as of 8/24/18 (Date)

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

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.103(g) - Food shall be stored in closed or sealed containers.

2a. DESCRIPTION OF VIOLATION
There was a unsealed plastic bag of prepared eggs in the main kitchen, on 6/4/18.

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.

Dining staff will be in-serviced on the proper procedures to store open food by 8/20/18

Ongoing:
Dining manager weekly will check compliance for proper food storage

Administrator will conduct periodic inspections of food to ensure All food is maintained in closed or sealed containers, starting Immediately @ 8/24/18

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

Date 8/9/18

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Plan of correction implementation status as of 6/24/18 (Date)

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

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.103(l) - Outdated or spoiled food or dented cans may not be used.

2a. DESCRIPTION OF VIOLATION
There was a dented can of prunes in the main kitchen storage area.

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.

Dining staff will be in-serviced on dented can policy and procedures importance of removing can from production.

Ongoing:
Dining manager weekly will check compliance of the policy ensure all dented cans are stored away from other can used in production

The administrator will conduct monthly or periodic checks of all stored cans of Food to ensure all dented cans are discarded, starting Immediately. 8/24/18

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

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Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600

2600.107(b) - The home shall have written emergency procedures that include the following:
(1) Contact information for each resident's designated person.
(2) The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
(3) Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
(4) Means of transportation in the event that relocation is required.
(5) Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
(6) Alternate means of meeting resident needs in the event of a utility outage.

2a. DESCRIPTION OF VIOLATION

The home's written emergency procedures do not include duties of staff, confidentiality of records, or contact information of residents' designated persons.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Home written emergency procedures will be updated by 8/31/18

Ongoing:
Director of environmental services will update the plan as needed when change occur
PCH Administrator will check compliance during monthly rounds

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

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

Date 8/9/18

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Plan of correction implementation status as of 8/24/18 (Date)

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- ☐ Not Implemented

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2000
2600.132(f) - Alternate exit routes shall be used during fire drills.

2a. DESCRIPTION OF VIOLATION
The home used the same exit to evacuate residents during fire drills on 05/8/18, 05/7/18, 4/24/18, 04/20/18, 03/22/18, 03/16/18, 02/25/18, 02/19/18, 01/25/18, 01/19/18, 12/23/17, and 12/26/17. The home evacuates using common link, or bridge, and stair wells. The fire safety documents specify use of "all exterior exits" but at no time did the residents evacuate to the outside of the building according to both resident and staff interviews.

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.

Fire Saftey expert Inspecton will be conducted by 9/30/18. Fire saftey letter will be updated to to included Interior exits thare are fire rated for safety ea
Crocker Fire Company notified to alternate exits during the montly fire drill, starting Immediately. ea 8/24/18
Ongoing:
Director of environmental services will review monthly fire drill documentation for complian
Any non-compliance the DES will conduct another drill within the month that will be in compliance with 2600.132 (f) regulation
PCH administrator will review all fire drill documentation monthly for compliance

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

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

Date 8/9/18

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The above plan of correction was approved by EW (Initials)

Plan of correction implementation status as of 8/24/18 (Date)

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

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

2a. DESCRIPTION OF VIOLATION
During fire drills, the staff and residents are evacuated to the "common link or bridge" as a fire safe area. The fire safety expert letter dated 09/20/17 indicates the stairwells as areas of refuge, not the link.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Fire saftey inspection will be conducted by 9/30/18. Fire saftey letter will be updated to include all fire safe areas. The residents will not be evacuated to the link since it is not indicated as of Fire Safe area, starting immediately @ 8/24/18.
Ongoing:
DES and PCH Administratorwill annually review all fire saftey documentation to include all fire safe area for compliance.

The administrator will observe fire drills on a quarterly basis to ensure residents are evacuated to Fire safe areas ONLY, starting immediately, @ 8/24/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tiffanie Small PCM — Date 8/9/18

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Plan of correction implementation status as of 8/24/18 (Date)

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Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

1. REGULATION 55 Pa.Code §2600
2600.201 - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself/herself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

2a. DESCRIPTION OF VIOLATION
Resident #2 displays sexually inappropriate behaviors towards staff and other residents. The home has not implemented positive interventions to modify or redirect the behavior.

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.

Resident rasp updated at time of inspection to include positive interventions for behaviors. All Residents with behavioral issues RASP will document directions for STAFF on
Ongoing: Redirection techniques, starting immediately. GW 8/24/18
Nurses in-serviced on updating Rasp for behaviors, positive interventions and documentation on 6/7/18 (see attachment K)
RSM and PCH Administrator will audit RASP quarterly for updates and compliance of all residents
starting immediately GW 8/24/18

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tiffanie Small PCM | Date 8/9/18

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The above plan of correction was approved by GW (Initials)

Plan of correction implementation status as of 8/24/18 (Date)

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- ☐ Not Implemented

Violation Report: 10063 - 05/29/2018 - Wooters, Sandra
PCH Name: STEWARD PLACE

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
The RASP dated 02/4/18, for resident #2, does not include information regarding their spontaneous bruising. condition.

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.

RASP updated at the time of inspection to include spontaneous bruising. All resident records will be audited within the next 30 days to ensure all needs are identified. SD 8/24/18
Nurses in-serviced on updating RASP with new diagnosis and symptoms on 6/7/18
(see attachment K)

RSM and PCH Administrator will audit RASP quarterly for updates and compliance

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

Signature of Legal Entity Representative (Required on EVERY Page) Tiffanie Small

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Tiffanie Small RSM | Date 8/9/18

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The above plan of correction was approved by SD (Initials)

Plan of correction implementation status as of 8/24/18 (Date)

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- ☐ Not Implemented