



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Mailing Date: September 27, 2018

Mr. Robert Rundle,
President/CEO
Spiritrust Lutheran
1050 Pennsylvania Avenue
York, Pennsylvania 17404

RE: Spiritrust Lutheran The Village at Gettysburg
1075 Old Harrisburg Road
Gettysburg, Pennsylvania 17325
Certificate #: 344420

Dear Mr. Rundle:

As a result of the Department's Bureau of Human Services Licensing inspection on September 19, 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.

Sincerely,

A handwritten signature in black ink, appearing to read "Brett Swanger".

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 34442 - 09/19/2018 - Springs, Israel
 PCH Name: SPIRITRUST LUTHERAN THE VILLAGE AT GETTYSBURG

1. REGULATION 55 Pa.Code §2600
 2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION
 The home reported an incident to the Department on 9/5/18. This was four days after the actual incident that occurred on 9/1/18.

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.

Refer to Pages 2A and 2B

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)	Date
Melinda Roth PCHTA	9-27-18

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

The above plan of correction is approved as of <u>9/27/18</u> (Date)	Plan of correction implementation status as of <u>9/27/18</u> (Date)
The above plan of correction was approved by <u>BAS</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

SpiriTrust Lutheran the Village at Gettysburg
September 24, 2018,
License # 344420
Melinda Roth PCHA

1. The Regulation cited during our annual inspection under 2600.16(c) is important because it ensures that the home shall report the incident or condition to the Department's Personal Care Home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (related to abuse reporting covered by law)
2. The violation was violated because the PCHA (myself) failed to report an incident in a timely manner. The incident occurred on 9/1/2018 and the incident was not reported until 9/5/2018
3. The cause of the error was that the Administrator (I) failed to recognize that this was a reportable incident at the time of the incident. I reported it when we discussed at resident review and different angles were talked about.

4 Plan of Correction

1. PCHA immediately reviewed the regulations concerning reportable incidents under 2600.16 (C).
2. PCHA gave information to all nursing staff on what qualifies as a reportable incident.

5. Prevention of Future Violations:

PCHA or designee will report within 24 hours on conditions including the following:

- (1) The death of a resident.
- (2) A physical act by a resident to commit suicide
- (3) A serious bodily injury or trauma requiring treatment at a hospital or medical facility. This does not include minor injuries such as sprains or minor cuts.
- (4) A violation of a resident's rights
- (5) An unexplained absence of a resident for 24 hours or more or when the support plan so provides, a period of less than 24 hours, or an absence of a resident from a secured dementia care unit.
- (6) Misuse of a resident's funds by the home's staff person or legal entity
- (7) An outbreak of a serious communicable disease
- (8) Food poisoning of residents
- (9) A physical or sexual assault by or against a resident.
- (10) Fire or structural damage to the home
- (11) An incident requiring the services of an emergency management agency, fire department, or law enforcement agency except for false alarms
- (12) A complaint of resident abuse, suspected resident abuse or referral of a complaint of resident abuse to a local authority
- (13) A prescription medication error
- (14) An emergency in which the procedures under emergency preparedness are implemented
- (15) An unscheduled closure of the home or the relocation of residents

9/27/18
Melinda Roth PCHA

- (16) Bankruptcy filed by the legal entity
 - (17) A criminal conviction against the legal entity, administrator or staff that are subsequent to the reporting on the criminal history checks
 - (18) A termination notice from a utility
 - (19) A violation of health and safety laws listed in 2600.18
6. Melinda Roth Administrator will be responsible for preventing future violations. Incidents will be reviewed when they occur to ensure reported per regulations. Reportable Events will be reviewed at Quality Management for recommendations and any Further follow-up needed.

4/27/15
Melinda Roth PCHH.