pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: natiyeh@yahoo.com
MAILING DATE: November 5, 2019

Ms. Nimita Kapoor-Atiyeh
Co-Administrator/President
Saucon Valley Manor Inc.
1050 Main Street
Hellertown, Pennsylvania 18055

RE: Saucon Valley Manor
License #: 205810

Dear Ms. Kapoor-Atiyeh:

As a result of the Department's Bureau of Human Services Licensing inspection on July 22, 2019, July 26, 2019 and August 13, 2019 of the above facility, the citations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Violation Report

Violation Report

Facility Information

Name: *SAUCON VALLEY MANOR* **License Number:** *20581*
Address: *1050 MAIN STREET,, HELLERTOWN, PA 18055*
County: *NORTHAMPTON* **Region:** *NORTHEAST*

Administrator

Name: *NIMITA KAPOOR-ATIYEH* Wendy Abreu **Phone:** **Email:** *NATIYEH@YAHOO.COM*

Legal Entity

Name: *SAUCON VALLEY MANOR INC.*
Address: *1050 MAIN STREET, HELLERTOWN,, PA, 18055*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** **Issued By:**

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *321* **Waking Staff:** *241*

Inspection

Type: *Partial* **BHA Docket #:** **Notice:** *Unannounced*
Reason: *Complaint,Incident*

Inspection Dates and Department Representative

07/22/2019 - On-Site: Gerald Dumas, Ryan Yankowy

07/26/2019 - On-Site: Gerald Dumas, Jason Harvey

08/13/2019 - On-Site: Gerald Dumas, Ryan Yankowy

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *268* **Residents Served:** *206*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *N/A* **Capacity:** *100* **Residents Served:** *74*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *206*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *115*
Have Physical Disability: *1*

142a - Secure Medical Care

Regulations

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On 7/12/19, at approximately 6:00 a.m. Staff person A finished showering Resident # 1. Staff person A required assistance in dressing the resident after the shower was completed. Staff person A went to request assistance from staff person B, who was in the next room. Staff person A then observed resident # 1 falling head first onto the bathroom floor from the shower chair they were sitting on. Resident # 1 fell on their left side onto the bathroom floor. Staff person B joined staff person A in the bathroom and observed resident # 1 on the floor. Staff person B directed Staff Person A to pick resident # 1 off the floor. Resident was placed back in the shower chair by staff person A, at which time Staff Person B observed a cut near the resident's left eye, which was bleeding. Staff Person B applied a towel to the resident's face which stopped the bleeding. Staff attempted to use two-way radios to summon supervisory assistance, but they were inoperable. Staff person B then directed staff person A to find the med tech supervisor (staff person C) for the shift. Staff Person C was located and assessed the resident. The resident was then transferred back into their bed by use of a Hoyer lift. No written or verbal communication occurred between the 3rd and 1st shifts regarding the fall incident. At approximately 8:15am, 1st shift staff person D came into the room and found resident # 1 in bed with resident's left eye black and blue and a cut near the left eye. At 9:30 a.m., staff person F, who is an R.N. assessed the resident in the dining room, noting a cut by the eyebrow and swelling on the left side of the resident's face. When staff person F questioned if the resident had pain, the resident did not answer. Resident flinched when staff person F lightly palpated close to the cut. Several minutes later, staff person E noted blood coming from the resident's nose at which time the resident was sent out to the emergency room. Resident was discharged from the emergency room with a closed fracture of left zygomatic arch (HCC). The 3rd shift Staff failed to assist resident #1 in securing timely medical attention after the fall by not immediately sending them out for further examination or putting a plan in place to closely monitor the resident after a fall in which they struck their head. Additionally, staff failed, at a minimum, to contact resident #1's primary care physician for direction or complete an internal incident report regarding the fall as outlined in the home's Fall Policy. There was also a failure by the 3rd shift staff to communicate verbally or in writing to the oncoming 1st shift regarding resident # 1's fall.

Resident # 2 developed a Stage 2 sacral slit on 4/18/19, to be cleaned and bandaged twice weekly. On 5/6/19 & 5/7/19 direct care staff member "G"notes must see the Doctor. Interviews with direct care staff member "F" acknowledge that the staff member failed to put the residents name on the list for the doctor to see for the week on 5/16/19. The doctor completes weekly wound care rounds at the home on Thursdays. On 5/21/19 direct care staff member "G" notes the resident needs to be seen by the doctor ASAP. The resident was seen by the doctor on 5/23/19. Notes from the doctor on 5/23/19 indicate that the ulcer had a strong malodor, the ulcer base has 100% necrotic tissue which probes to the bone. The ulcer measured 2.0 x 2.0 x 2.5 cm Stage 4 wound after debridement. The home failed to assist the resident secure medical care when the resident's health status declined on 5/6 & 5/7/19.

142a - Secure Medical Care *(continued)* P 2A of 4

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.)

Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the License Inspection Summary. This Plan of Correction is prepared and submitted to meet requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to 55 Pa. Code §55 Pa. Code 20 et seq. and 2600.263.

Please note that Personal Care Home strongly disagrees with the violation 2600.142(a) for the following reasons. Staff person A does acknowledge that he/she saw Resident # 1 fall from her shower chair out of the corner of his/her eye but it was never indicated that Resident # 1 fell head first. At time of incident Resident # 1 was assessed by Staff person C and besides Resident # 1 having a skin tear, Resident # 1 expressed no other signs or symptoms of any injury. Please note that Staff persons A and C are both CPR/ First aide certified. When Staff Person D arrived for the start of his/ her shift and went to check on Resident # 1, Staff person D noticed that resident #1 had a cut near his/her left eye which was starting to turn black and blue. Staff person D immediately notified Staff member E as well as Administration. Administration notified PCP and family. The family of Resident #1 indicated that they did not want Resident #1 to be sent to ER but would like him/ her to be seen by PCP. Personal Care Home staff expressed family's wishes to PCP however PCP did not have any openings for resident #1 to be seen that morning. Please note PCP was given all information in regards to Resident #1's current condition and PCP did not indicate any urgency of Resident #1 needing to be seen but instead ordered an in-house x-ray to be done which was at the request of the family. While Personal Care Home was communicating between PCP and Resident #1's family, Administration of Personal Care Home asked Staff Member F who is an R.N. to assess Resident #1. Resident #1 was assessed by Staff Member F. Staff member F speak to Staff Member E regarding the assessment and as Staff member F was about to leave dining room area he/ she was called back as Resident# 1 was now experiencing nose bleed. Staff member F informed staff that Resident # 1 needed to go to the ER. Administration agreed with Staff members F's assessment and informed the family of Resident #1 as well as the PCP that we could no longer wait for in house x- ray as per family's request. Resident # 1 was immediately sent to the ER. Please note that again Staff member A did acknowledge that he/she saw Resident #1 fall out of shower chair but never indicated that resident # 1 hit their head therefore 3rd shift did not fail to secure resident # 1 medical attention as based on assessment at that time by Staff member C in which resident # 1 did not have any signs/symptoms of any injuries other than skin tear. Furthermore, Personal Care Home did notify PCP in the morning of the incident when PCP arrived at office and Personal Care home was in communication with office several times regarding Resident # 1 being seen as well as in house x-ray being ordered as per the family's request. Also, Personal Care Home was in communication with PCP several times the morning of the incident which was documented by PCP office and provided to the inspectors at the time of inspection. Once resident # 1 showed signs and symptoms of possible injuries other than the skin tear resident # 1 was immediately sent out and family and PCP were notified of the personal care homes decision.

Please see page 3a for continued response

Legal Entity Representative

Co-Owner - President

Nimita Kapoor - Atty

10/1/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 11-4-19 (Date)

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

Plan of correction implementation status as of 11-4-19 (Date)

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

142a - Secure Medical Care *(continued)*

Plan of Correction (POC)

Pg 3a

(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.)

In regards to Resident #2 Staff Member G indicated on 5/6/19 that Resident #2 must go and see Doctor as a heads up to staff. There was no urgency indicated at this time. Resident #2 continued to receive wound treatments as ordered by PCP and Staff Member F, who does wound rounds with the wound doctor on a weekly basis, saw the wound on 5/11 and felt that the current wound orders for Resident #2 were appropriate at the time and did not see the urgency to see the wound doctor. It was not until 5/21 in which Staff Member G indicated urgency for Resident #2 to see the wound physician. Resident #2 was immediately put on the list for that week and Resident #2 was seen by wound physician on 5/23. Please also note that Resident #2 was seen in the hospital on 5/6 in which he/she was sent out due to a fall onto his/her buttocks as well as on 5/14 in which Resident # 2 had a procedure on his/her lumbar region. Per hospital records received there was no indication in regards to a sacral wound in which needed immediate attention.

To ensure continued compliance, Personal Care Home has already re-reviewed communication between shifts in which in-service was held with 11-7 shift on a 1:1 basis. (please see attached) All nursing supervisors will be enforcing communication between shifts both electronically as well as verbally. Rasp updates will continue on timely basis and will be reviewed daily by RASP coordinator and overseen by Administration.

In addition Administration has met with the R.N.'s and L.P.N.'s in regards to documentation and communication regarding wound treatments. Personal Care Home has established that VNA services as well as wound physician will continue for any resident with a wound which requires wound care if they qualify for VNA services. For any resident which does not qualify for VNA services, wound treatment will be completed based on the physician's orders. Wound care will be completed by the R.N.'s and L.P.N's and will be overseen by the wound physician. This will be overseen by the Unit Clerk on a daily basis as wound orders come into the facility. In addition this procedure will be monitored by Administration on a weekly basis.

In a follow up call with the home, residents will exercise their choice of home health provider. The term "VNA" used above was used as a generic term to refer to home health agencies in general, not the Visiting Nurses Association specifically. 11-4-19 ag

Legal Entity Representative

Signature

Nimita Kapoor Atwell — Printed Name and Title

10/1/19 — Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 11-4-19 (Date)

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

Plan of correction implementation status as of 11-4-19 (Date)

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

234d - Support Plan Revision

Regulations

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

Resident # 2's RASP dated 4/10/19 was not updated to reflect the resident needing to be repositioned to offload the residents pressure ulcer as indicated by the doctor on 5/23/19.

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.)

Preparation and submission of this Plan of Correction does not constitute an admission or agreement by the personal care home of the truth of the facts alleged or of the correctness of the conclusion set forth on the License Inspection Summary. This Plan of Correction is prepared and submitted to meet requirements under state law. The personal care home reserves any and all applicable rights to appeal pursuant to 55 Pa. Code §55 Pa. Code 20 et seq. and 2600.263.

Please note that Personal Care Home respectfully disagrees with this violation as this was a mere documentation error and the information regarding Resident #2 needing to be repositioned was in the medical file it was just not transferred to the resident's support plan. Resident #2's medical file is located in the wellness center and is accessible to the nursing staff at all times.

To ensure continued compliance Personal Care Home will check and re-check doctor's orders in their entirety as they are written so that pertinent information is not missed and all pertinent information will be included onto the Resident Assessment Support Plan. This will be done by RASP coordinator and all updates will be reviewed by Administration on a weekly basis.

Legal Entity Representative

Signature | Printed Name and Title: Co-Admr + Resident Nimita Kapoor-Atrish | Date: 10/1/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 11-4-19 (Date)

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

Plan of correction implementation status as of 11-4-19 (Date)

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