



**Sent via e-mail cbetts@devereux.org
Sent via e-mail rwright5@devereux.org
May 6, 2020**

Mr. Chris Betts
Executive Director
Devereux Foundation, Inc.
139 Leopard Road
Berwyn, Pennsylvania 19312

RE: Devereux PA Adult Services PCH - Hillcrest Cottage
229 Leopard Road
Berwyn, Pennsylvania 19312
License #: 198140

Dear Mr. Betts:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 27, 2019 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Sandra Wooters

Sandra Wooters, MHS, ACG
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *DEVEREUX PA ADULT SERVICES PCH - HILLCREST COTTAGE*
Address: *229 LEOPARD ROAD,, BERWYN, PA 19312*
County: *CHESTER* Region: *SOUTHEAST*

License Number: *19814*

Administrator

Name: *Rancy Wright*

Phone: *6102966800*

Email:

rwright5@devereux.org, bfarley@ad.devereux.org

Legal Entity

Name: *DEVEREUX FOUNDATION INC*
Address: *139 LEOPARD ROAD, BERWYN, PA, 19312*

Certificate(s) of Occupancy

Type: *C-2 LP*

Date: *12/13/2001*

Issued By: *Commonwealth of PA, L&I*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *15*

Waking Staff: *11*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

11/27/2019 - On-Site: Dean Gray

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *21*

Residents Served: *13*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *0/0*

Number of Residents Who:

Receive Supplemental Security Income: *4*

Are 60 Years of Age or Older: *4*

Diagnosed with Mental Illness: *4*

Diagnosed with Intellectual Disability: *7*

Have Mobility Need: *2*

Have Physical Disability: *0*

17 - Record Confidentiality

Regulations

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 11/27/19, the resident records were unlocked, unattended, and accessible in the basement conference room.

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.)

A work order was entered with our maintenance department for a new lock to be placed on the cabinet that is used to stored residents' records.

Moving forward the cabinet will be locked at all times for the purpose of confidentiality stipulated in regulation 2600.17. The nurse will make sure the cabinet is remained locked after a retrieval of any information from resident records.

Legal Entity Representative

Rancy Wright
Signature

Rancy Wright 11/3/20
Printed Name and Title Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

Personal Care homes must post the required influenza information in a public place in the home year round as required by the Influenza Awareness Act (HB 1785). The home did not have an influenza poster anywhere.

Repeat Violation: 01/14/19

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.)

On 11/28/2019, an infleunza poster was posted in the home.

Moving forward, the program supervisor will conduct quarterly check/walked through for the poster and other relevant information that need to remained posted in the home at all tiimes. Also, the administrator will carryout semi annual walked-through for the same purpose and check other documentation for compliance purpose.

Legal Entity Representative

Randy Wright
Signature

Randy Wright *1/3/20*
Printed Name and Title Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

65d - Initial Direct Care Training

Regulations

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, an intellectual disability 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, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on 11/12/18 for another department within Devereux, filled in at Hillcrest Cottage and was providing unsupervised ADL services on 11/10/19. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

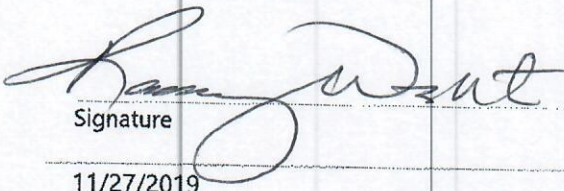
Plan of Correction (POC)

(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.)

After discovery, staff person A was scheduled for Department-approved direct care training course. On 12/1/2019 staff person A completed the training.

Moving forward, the program supervisor will make sure every new hired completes the DPW competency training before getting in rotation to work with any resident in the program.

Legal Entity Representative


 Signature
 11/27/2019

Nancy Wright
 Printed Name and Title
 1/3/20
 Date

65d - Initial Direct Care Training *(continued)*

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

90b - Staff Communication

Regulations

2600.

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

The home does not have a system that allows staff in different parts of the home to communicate with each other in an emergency. On 11/27/19, the home served 13 residents.

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.)

After the inspection a request to purchase walkie-talkies for the program was forwarded to the center's business department on 11/30/2019 and the purchased was made for the program.

Moving forward, the program will maintain the walkie-talkie as the method of communication between staffs for the safety of the residents in an event of an emergency.

Legal Entity Representative

Rancy Wright
Signature

Rancy Wright 1/3/20
Printed Name and Title Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

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

Implemented
 Not Implemented

105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 11/27/19, there was an accumulation of lint in the lint trap of the dryer in the laundry room. There were no clothes in the dryer at the time.

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.)

The lint trap was cleared immediately after the discovery.

Moving forward, staffs will conduct daily checks after every resident completes his/her laundry and cleared lint trap when lint is found. Also, supervisor will emphasize the daily checks and clearing of the lint trap in every monthly staff meeting.

Legal Entity Representative

Rancy Wright
Signature

Rancy Wright
Printed Name and Title

1/3/20
Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

132g - Fire Drills Days/Times

Regulations

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The fire drills completed on 01/08/19, 02/05/19, 03/05/19 and 04/30/19 were all completed on a Tuesday.

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.)

After the discovery, a schedule was developed by the center's Quality Management Department with specific days of a week that fire drills have to be conducted.

Moving forward, the supervisor will reviewed every completed fire drill form to ensure that there is no repetition of the same day and drills are conducted on the assigned days.

Legal Entity Representative

Rancy Wright
Signature

Rancy Wright *1/3/20*
Printed Name and Title Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

144c1 - Smoking Area Guidelines

Regulations

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area includes a discarded area rug and chairs that do not meet the fire resistant guidelines.

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.)

The rug was removed immediately after the discovery on 11/27/2019.

Moving forward, the supervisor will conduct a routine check/walked-through to make sure that the designated smoking area is cleared of any fire hazardous items

Legal Entity Representative

Raney Wright
Signature

Raney Wright
Printed Name and Title

1/3/20
Date

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

The above plan of correction is approved as of 5/6/2020
(Date)

Plan of correction implementation status as of 5/6/2020
(Date)

- Implemented
- Not Implemented

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

11/27/2019