pennsylvania
DEPARTMENT OF HUMAN SERVICES

**Mailing Date: April 29, 2020**

Mr. Craig Cordell,
Executive Director
Visions of South Central PA, Inc.
152 South Second Street
Chambersburg, Pennsylvania 17201

RE: New Visions Inc.
103 Deerview Drive
Newville, Pennsylvania 17241
Certificate #: 328700

Dear Mr. Cordell:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 27, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

# Violation Report

## Facility Information

Name: *NEW VISIONS INC* License Number: *32870*
Address: *103 DEERVIEW DRIVE,, NEWVILLE, PA 17241*
County: *CUMBERLAND* Region: *CENTRAL*

## Administrator

Name: *Megan Estes* Phone: Email:

## Legal Entity

Name: *NEW VISIONS OF SOUTH CENTRAL PA INC*
Address: *138 EAST KING STREET, SHIPPENSBURG, PA, 17257*

## Certificate(s) of Occupancy

Type: *R-4* Date: *10/04/2017* Issued By: *Upper Frankford Township*

## Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *7* Waking Staff: *5*

## Inspection

Type: *Full* BHA Docket #: Notice: *Unannounced*
Reason: *Renewal*

## Inspection Dates and Department Representative

*02/27/2020 - On-Site: Jason McCloskey*

## Resident Demographic Data as of Inspection Dates

### General Information

License Capacity: *7* Residents Served: *7*

### Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

### Hospice

Current Residents: *0*

### Number of Residents Who:

Receive Supplemental Security Income: *5* Are 60 Years of Age or Older: *5*
Diagnosed with Mental Illness: *7* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *0* Have Physical Disability: *0*

## 16c - Written Incident Report

### Regulations

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 § 2600.15 (relating to abuse reporting covered by law).

### Description of Violation

-On 1/2/20, Resident 1 was administered a calcium supplement for the second consecutive day. This medication is prescribed to be given every other day. This medication error was not reported to the Department until 1/6/20.

- On 12/28/19, Resident 2 was not administered a prescribed dose of Lasix at 2pm. This medication error was not reported to the Department until 12/30/19.

- On 10/1/19, Resident 2 was not administered the prescribed Amlodipine 10mg and Metoprolol Succinate XL 25mg. These medication errors were not reported to the Department until 10/7/19.

### 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.)

-All staff will be re-educated on proper incident reporting procedures at the staff meeting scheduled for 3/12/2020. Any staff not present at the meeting will be re-educated separately by Administrator by 3/16/2020.

-All incident reports will be written as soon as possible after the incident or after discovery of a medication error. Staff writing the incident report will allow a second staff member (on shift or the following shift) to proof-read the report for clarity and completion. The staff member will fax the incident report to the DHS Central Regional Office within 24 hours of the incident. The incident report will then be given to Administrator for review and filing. These steps will be put in effect immediately.

-Overnight staff will complete a daily review of the MARs for four weeks, to make sure that all medication errors are being caught and reported to the Department within the 24 hour time slot. This documentation will be submitted to the Department by 4/17/2020.

### Legal Entity Representative

MG. Estes, BA — Signature

Megan G. Estes, BA PCH Administrator — Printed Name and Title

3/12/2020 — Date

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

The above plan of correction is approved as of 3/12/2020 (Date)

Plan of correction implementation status as of 4/29/2020 (Date)

XX ☒ Implemented

☐ Not Implemented

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

## 132e - Fire Drill Sleeping Hours

### Regulations

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

### Description of Violation

The home conducted fire drills during sleeping hours on 9/17/19 and 2/15/19. These drills were held more than 6 months apart.

### 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.)

-Administrator creates a tentative fire drill schedule by December 31 of each calendar year, for the following year. During the creation of this schedule, Administrator will look at the timing between overnight fire drills and adjust so that fire drills held during sleeping hours are no more than 6 months apart.

-Current fire drill schedule was reviewed. Adjustments were made so that overnight fire drills will be held within 6 months of each other. 2020 overnight fire drills are tentatively scheduled for March 2020 and September 2020.

-Administrator will provide documentation of March 2020 fire drill to the Department by 4/5/2020.

### Legal Entity Representative

MMp-C-Estes,BA
Signature

Megan G. Estes, BA PCH Administrator 3/12/2020
Printed Name and Title Date

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## 224a - Preadmission Screen Form

### Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

### Description of Violation

Resident 3's preadmission screening form, dated 11/26/19, does not include a determination that the needs of the resident can be met by the services provided by the home.

### 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.)

-At the time of inspection on 2/27/2020, Residential Director corrected the preadmission screening form for Resident 3, in front of the representative, to reflect the determination that the needs of the resident could be met by the services provided in the home.

-Administrator completes all preadmission screening forms for new residents. Residential Director will review all preadmission screening forms for completion, within 30 days prior to the resident's admission to the personal care home. This will be implemented during the next admission.

-Administrator did an immediate audit of the two admissions in the past year, and all information was present on the preadmission screenings for both residents.

### Legal Entity Representative

MG Estes BA — Signature

Megan G. Estes, BA PCH Administrator — Printed Name and Title

3/12/2020 — Date

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