Sent via e-mail thansen-turton@woods.org
Sent via e-mail dshaffer@woods.org
June 30, 2020

Ms. Tine Hansen-Turton
President
Woods Services, Inc.
Attn: Dawn Shaffer
469 East Maple Avenue
Langhorne, Pennsylvania 19047

RE: Beechwood Center 4
586 Beechwood Circle
Langhorne, Pennsylvania 19047
License #: 129660

Dear Ms. Hansen-Turton:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on April 3, 8, 10, 13, and 15, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Claire Mendez

Claire Mendez
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *BEECHWOOD CENTER 4*
License Number: *12966*
Address: *586 BEECHWOOD CIRCLE, LANGHORNE, PA 19047*
County: *BUCKS*
Region: *SOUTHEAST*

Administrator

Name: *Arlene Serrano*
Phone: *2157504001*
Email: *DShaffer@WOODS.ORG*

Legal Entity

Name: *WOODS SERVICES, INC.*
Address: *469 E. MAPLE AVE., ATTN DAWN SHAFFER, LANGHORNE, PA, 19047*

Certificate(s) of Occupancy

Type: *C-1*
Date:
Issued By:

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *9*
Waking Staff: *7*

Inspection

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

Inspection Dates and Department Representative

04/03/2020 - Off-Site: David Carrion

04/08/2020 - Off-Site: David Carrion

04/10/2020 - Off-Site: David Carrion

04/13/2020 - Off-Site: David Carrion

04/15/2020 - Off-Site: David Carrion

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8*
Residents Served: *8*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Diagnosed with Mental Illness: *0*
Have Mobility Need: *1*
Are 60 Years of Age or Older: *4*
Diagnosed with Intellectual Disability: *0*
Have Physical Disability: *0*

42b - Abuse

Regulations

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On March 28 at 2:30 am, Resident #1 was awakened by the shift nurse to check his temperature. At that time, Resident #1 requested that Staff member A change his adult brief. Staff member A asked staff member B to help him to change his brief because the resident required additional assistance due to his partial paralysis. Afterwards, Resident #1 requested to be dressed and be taken to the dining room. Resident #1 wanted to eat breakfast at 2:30 am. Staff member B brought him a glass of water. Resident #1 again requested breakfast food. Staff member A, who was working as his one-on-one attendant, stated that it was "too early to eat breakfast". At 3 am, Resident #1 was wheeled to the dining room by Staff member A. Staff member A refused the resident's request for cereal stating that was not aware of resident #1 diet or medications. After a heated discussion, heard by staff member B, Resident #1 grabbed a soda out of his personal refrigerator. Resident #1 wheeled himself to the living room.

At 4:30 am, Resident #1 wheeled himself back to the dining room and fell asleep with his head on top of dining table. Staff member A left resident #1 sleeping at the dining table, and did not take resident #1 back to the room, because, per staff member A's statement, it was almost time for breakfast, and he would have to be up by then. Staff Member C, who normally provides Resident #1's morning care, came in at 7 am and found Resident #1 snoring and drooling on the dining table. Staff member A told Staff member C that Resident #1 wants to eat breakfast, and Staff member A proceeded to leave.

Per the resident's RASP, dated 2/5/2020, he requires moderate assistance with supervision 24 hours a day and required one on one service due to his increased falls and a recent back fracture, stating that he is impulsive, and will get up at any given moment which could result in a fall. The RASP also states that he needs assistance with judgment, as the resident is impulsive and this can lead to decisions that are harmful to him. To assist the resident, Staff are to provide verbal cues for redirection.

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.)

Please see attached

Legal Entity Representative

[signature] Dawn Shaffer, Res Director 6/24/2020

Signature | Printed Name and Title | Date

42b - Abuse *(continued)*

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The above plan of correction is approved as of 6/30/2020 (Date)

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

Plan of correction implementation status as of 6/30/2020 (Date)

- [x] Implemented
- [ ] Not Implemented

Dawn Shaffer Res Director 6/24/2020

Plan of Correction: Beechwood Center 4, 586 Beechwood MM_6_22_2020

Regulation 42b Abuse:

Regulation 2600.42b: a resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. This regulation is important to protect residents from abuse and neglect. On March 28, 2020 Staff A, was reassigned to Beechwood Center 4, due to staff shortage on the 11pm - 7am shift. At approximately 2:30am Resident 1 was awoken by the nurse to complete a neuro check. Once check was completed the resident requested breakfast. Staff A, verbally redirected resident by stating "it was too early for breakfast", as it was 3am. Resident 1 still wanted to get up and go out to the dining room. Staff A, assisted Resident into his wheelchair, and accompanied resident as resident propelled his wheelchair to the dining area. Resident 1, requested cereal. Staff A explained again that it was 3am and that breakfast is served at 7am. Staff A attempted to orient Resident to time and suggested resident may want to return go to sleep. Resident 1 opened his personal refrigerator and drank half of a soda and returned it to the refrigerator. Resident 1 left dining area and went to the living room to watch TV. Staff A, followed Resident 1. Resident 1 propelled himself back to the dining area opened his refrigerator and finished the soda. Staff A, asked Resident 1 if he wanted to go back to his bedroom to sleep. Resident 1 stated "no". Resident 1 continued to sit at the table and eventually laid his head down on the table and fell asleep and remained until 7am.

This incident was investigated internally by a Pennsylvania certified investigator. The investigation concluded that that incident was not confirmed for abuse or neglect. Findings determined Staff A violated Woods Policy of Supervision. As a result, Woods (Beechwood Center #4) does not agree with the determination that this incident violated regulation 2600.42b. The plan of correction includes:

1. With recommendation of Human Services Licensing Supervisor , Staff A cleared to return to work at Beechwood Center 1 only with no further contact with Resident 1, after further training was completed.
2. Staff A participated in further training in the topics of:
    a. Abuse
    b. Safety management techniques; including self-awareness, milieu of positive therapeutic environment, active engagement, relationship building and tools of crisis management, prevention and de-escalation.
    c. Ukeru program; safe, comforting, crisis management techniques which utilizes verbal and non-verbal communication, managing and de-escalating conflict by focusing on comfort verses control.
3. See attached documentation to support plan of correction.
4. All Beechwood Center 4 staff will continue to receive annual training in the topic areas required in regulation 2600.61.

Dawn Shaffer Res. Director 6/24/2020

161d - Dietary Needs

Regulations

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

Description of Violation

On 03/07/19, Resident #1 was prescribed a 1500 calorie diet consisting of dime sized pieces of food, no crunchy or hard foods, and low-calorie beverages. On 03/28/20 at 3 am, Resident #1 was awakened by a nurse who had taken his temperature. Resident #1 could not return to sleep and requested breakfast. Staff member A responded that it was not time for breakfast, but also did not provide the resident a snack stating that the Staff Member was not aware of of the resident's dietary needs. The information on Resident #1 dietary needs was accessible, but the staff member did not review it, stating that he was not familiar with the location of the record because he typically works in a different building on the campus.

Plan of Correction (POC)

steps to

Regulation 2600.161(d), a resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record. This regulation is important to follow the directions of a physician, physician's assistant, certified registered nurse practitioner, or dietitian regarding special dietary needs for a resident. A home not following a resident's special dietary needs, as prescribed by a physician, physician's assistant, certified registered nurse practitioner, or dietitian may generate dire health consequences for the resident. This regulation was violated by Staff A, due to unfamiliarity of Resident 1 and limited knowledge on how to access resident record in the electronic client record. Prior to electronic client record implementation, paper copy of client record was available in Beechwood Center 4. Staff A has been retrained in navigating the electronic health record for access to Resident Assessment and Support Plan, profile, diet, medications etc. Beechwood Center 4 has printed step by step photo instructions at the staff office desk to reference should any staff have difficulty locating this information in the electronic client record. Personal care home administrator/residential manager will provide ongoing monitoring of staff's knowledge and use of the ECR system and provide additional training support as needed.

Legal Entity Representative

Signature

Dave Shaffer - Residential Director — Printed Name and Title

6/24/2020 — Date

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☐ Not Implemented

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201 - Positive Interventions

Regulations

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself 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.

Description of Violation

Resident #1's RASP indicates that he needs assistance with judgment due to poor decision making. On 03/28/20 at 4:30 am, Resident #1 fell asleep with his head on the dining room table until 7:00 am where he was found by Staff Member C. Staff Member A failed to offer redirection, employ positive intervention or assist the resident in finding an appropriate place to sleep.

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.)

Regulation 2600.201, Safe Management Techniques, the home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, de-escalation techniques and alternative techniques or methods to identify and defuse potential emergency situations. This regulation is important to ensure that residents' behavioral needs are met in the least restrictive way possible. The regulation was violated by Staff A, for not attempting further redirection or for trying a different types of techniques to resident 1 after initial attempt was unsuccessful. To immediately address the insufficient compliance Staff A was assigned and has completed further training in Safe Management Techniques. PCH administrator/residential manager will insure all Beechwood Center 4 staff receive required annual training in Safe Management Techniques through monitoring of staff individual training plan and registering staff for training requirements. See attached documentation.

Legal Entity Representative

[signature] Dawn Shaffer Pro Director 6/24/2020

Signature | Printed Name and Title | Date

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