

Department of Human Services
Bureau of Human Service Licensing

August 19, 2020

VS WOODS LLC
6600 BROOKTREE COURT,SUITE 1000
INTEGRACARE CORPORATION
WEXFORD, PA, 15090

RE: THE WOODS AT CEDAR RUN
824 LISBURN ROAD
CAMP HILL, PA, 17011
LICENSE/COC#: 33132

Dear Ms. Pastick ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/25/2020, 07/22/2020 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 (LIS)

cs: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSE INSPECTION SUMMARY - PUBLIC**

Facility Information

Name: *THE WOODS AT CEDAR RUN* License #: *33132* License Expiration Date: *12/31/2020*
 Address: *824 LISBURN ROAD, CAMP HILL, PA 17011*
 County: *CUMBERLAND* Region: *CENTRAL*

Administrator

Name: *Heather Pastick* Phone: *7177373373* Email: *hpastick@INTEGRACARE.COM*

Legal Entity

Name: *VS WOODS LLC*
 Address: *6600 BROOKTREE COURT, SUITE 1000, INTEGRACARE CORPORATION, WEXFORD, PA, 15090*
 Phone: *7177373373* Email: *hpastick@INTEGRACARE.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *02/19/1997* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *80* Waking Staff: *60*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *07/22/2020*

Inspection Dates and Department Representative

06/25/2020 - Off-Site: Laura Heemer
07/22/2020 - Off-Site: Laura Heemer

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* Residents Served: *61*

Secured Dementia Care Unit

In Home: *Yes* Area: *SDCU* Capacity: *19* Residents Served: *19*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *61*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *19* Have Physical Disability: *2*

Inspections / Reviews

06/25/2020 - Partial

Lead Inspector: *Laura Heemer*Follow-Up Type: *POC Submission*Follow-Up Date: *08/02/2020*

8/11/2020 - POC Submission

Lead Reviewer: *Brett Swanger*Follow-Up Type: *Document Submission*Follow-Up Date: *08/29/2020*

8/19/2020 - Document Submission

Lead Reviewer: *Brett Swanger*Follow-Up Type: *Not Required*

23a - Activities of Daily Living Assistance

1. Requirements

2600.

- 23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

The resident assessment and support plan, dated 5/26/2020, for Resident #1 indicates the resident requires moderate assistance with supervision. On 6/20/2020, Resident #1 used a wheelchair leg to break a glass window in a bedroom and sustained minor cuts to hands as a result. At this time, the resident made the statement that he needed to get home to his wife and children. On 6/23/2020, Resident #1 went into another resident's bedroom, shut the door, disengaged the window safety locks, and eloped from the personal care home via the window. The home did not implement adequate supervision in response to the behaviors exhibited during the 6/20/2020 incident.

23a - Activities of Daily Living Assistance (continued)

Plan of Correction - 08/11/2020**Accept**

Please see attached documentation. Review of "Catastrophic Incidents" began daily review August 10, 2020.

1. *Violation Review:*

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

2. *Violation Interpretative Statement:*

The resident assessment and support plan, dated 5/26/2020, for Resident #1 indicates the resident requires moderate assistance with supervision. On 6/20/2020, Resident #1 used a wheelchair leg to break a glass window in bedroom and sustained minor cuts to hands as a result. At this time, the resident made the statement that he needed to get home to and children. On 6/23/2020, Resident #1 went into another resident's bedroom, shut the door, disengaged the window safety locks, and eloped from the personal care home via the window. The home did not implement adequate supervision in response to the behaviors exhibited during the 6/20/2020 incident.

3. *Review the benefit of the Regulation, per RCG:*

Ensures that residents' needs are met once those needs have been assessed and a plan to meet the needs has been developed

4. *Description of the Repair of the Immediate Problem:*

Resident #1 discharged from community to higher level of care due to worsening behaviors.

5. *Determine / document the Root Cause of the Violation:*

Resident service plan not reviewed and updated as needed when the initial event occurred dated 6/20/2020. Reevaluation and review of changing resident needs regarding oversight and/or additional therapeutic interventions not reviewed and/or implemented by staff.

6. *Detail Action Steps / System Developed to prevent future occurrence:*

For future similar circumstances as those listed for Resident #1; our Resident Wellness Director will develop guidelines within the plan of care for close monitoring of potential elopement risks and behaviors and to immediately seek the guidance and recommendation of primary care physician and Medical Director, as necessary. Nursing team will meet with family (via phone or in-person conference) immediately to review conversations which are concerning potential behaviors taken by resident and collaborate with family on alternative therapies or resources. Facility will solicit all available resources in the management of resident needs until a more immediate higher level of care in a more appropriate environment can be achieved.

Behaviors warranting a "Catastrophic Incident" Form will have a formal evaluation and collaboration between Director of Memory Care, Resident Wellness Director and Executive Operations Officer to evaluate what immediate needs in supervision are required for prevention of future events, as well as surveying resident behaviors and precursors to event. Nursing management team will educate staff members on changes in resident plan of care, increased monitoring if required, and mechanisms for prevention efforts. Nursing management team will review success of additional resources and prevention efforts of behaviors on at least a weekly basis or more frequently as deemed necessary.

Process change implementation August 10, 2020.

a. *Changing practice?*

Resident Wellness Director, Director of Memory Care and Executive Operations Officer to review daily "Catastrophic Incident" (s) and discuss interventions in prevention of further incidents, and review of potential precursors to incidents. Resident Wellness Director and Director of Memory Care will educate staff on changes in resident plan of

care and weekly review of implementation practices to prevent further incident.

b. *Teaching or Training?*

Training will be provided to staff on "Catastrophic Incident" reporting, documentation, assessment and processes for follow-up by Resident Wellness Director and Director of Memory Care. Training to be completed by August 15, 2020.

c. *On-going Monitoring?*

Daily review of "Catastrophic Incident" and weekly review of changes in resident plan of care in efforts of prevention by Resident Wellness Director and Executive Operations Officer.

d. *Designated position responsible and specify target date for correction.*

Daily review of "Catastrophic Incident" reports began on August 10, 2020. Executive Operations Officer will ensure staff training to be completed by August 15, 2020.

Completion Date: 08/10/2020

23a - Activities of Daily Living Assistance (continued)

Document Submission - 08/19/2020**Implemented**

Training on Catastrophic Incidents completed on all staff except 1 by/on August 15, 2020. Remaining staff member reviewed information on August 18, 2020. Daily review of new Catastrophic Incidents and preventative measures/implementation for prevention of future incidents reviewed at least weekly by Executive Director and Director of Memory Care for success in prevention--began August 10, 2020.

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

According to staff members, there are not enough staff members scheduled to provided the level of of supervision required by resident support plans in the Secure Dementia Care Unit when there is only one direct care staff person and one medication technician on duty. This is evidenced by:

1. The resident assessment and support plan, dated 5/26/2020, for Resident #1 indicates the resident requires moderate assistance with supervision. On 6/20/2020, Resident #1 used a wheelchair leg to break a glass window in bedroom and sustained minor cuts to hands as a result. At this time, the resident made the statement that needed to get home to and children. On 6/23/2020, Resident #1 went into another resident's bedroom, shut the door, disengaged the window safety locks and eloped from the personal care home via the window.

2. On 6/28/2020, Resident #2 had a fall at 12:15 pm in the resident's bedroom. The two staff members on duty had to leave the other Secure Dementia Care Unit residents in the dining room unsupervised while assisting Resident #2 with care. Residents in the dining room included Resident #3 who requires total staff assistance to eat and Resident #4 who requires continual prompting by staff to eat and drink. At that time, no staff was available to assist the residents' needs.

3. Resident #3 requires two person transfer assistance with the use of a Hoyer Lift. According to staff and to Hospice workers, these transfers take approximately fifteen minutes. Assistance to supervise the other residents of the Secure Dementia Unit is not always available when Resident 3 is being assisted by both scheduled staff people on duty.

4. Staff state the home would not be able to evacuate residents in an emergency based on the current staffing levels of one direct care staff assigned overnight in the Secure Dementia Care Unit. It is reported by staff members that in order to evacuate the residents of the Secure Dementia Care Unit during fire drills the staff member assigned to run the sleeping hours fire drills regularly assists with the evacuation of the residents. However, this staff member is not normally scheduled to work at that time, and is an extra employee scheduled to be on-site for the running of the drill.

60a - Staff/Support Plan (continued)

Plan of Correction - 08/11/2020**Accept**

Please see attached documentation. Staff education and training of use of available staff and appropriate staffing practices to be completed by Executive Operations Officer by August 15, 2020.

1. *Violation Review:*

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

2. *Violation Interpretative Statement:*

The staffing requirements required by § 2600.57(b)-(d) are the minimum allowable staff hours for regulatory compliance. Additional staff hours may need to be provided based on the needs identified in each resident's assessment-support plan. Examples of needs that may necessitate additional staffing include: Hands-on assistance to ambulate or evacuate from one or more persons, 24-hour direct supervision, an acute medical condition that requires special treatment or observation.

3. *Review the benefit of the Regulation, per RCG:*

Ensures that there are sufficient staff persons on duty at all times to meet residents' needs

4. *Description of the Repair of the Immediate Problem:*

Current staffing hours are equal or greater than regulation requirements within a 24 hour period. Circumstance noted in #2 occurred during daylight hours where nursing and ancillary staff are readily available and easily accessible to assist as needed in the event of an emergency. All current staff (of legal age) within the community have completed DCS training and testing to safely provide temporary oversight. Specifically in our memory care neighborhood, our FT memory care housekeeper has trained and worked as a nursing aide in her 8+ years in our community, we also have trained dining staff during breakfast and lunch to provide temporary oversight to the general mass of residents, temporarily if needed. Education to be provided to staff on practices to assist resident per service plan while maintaining appropriate staffing compliance.

5. *Determine / document the Root Cause of the Violation:*

Staff education to be provided to utilize our trained ancillary staff who are readily available within the community to assist in times of temporary emergent need, or needed oversight.

6. *Detail Action Steps / System Developed to prevent future occurrence:*

Education to be provided by August 15, 2020 to all nursing and ancillary staff to seek the temporary and flexible assistance of others within the community to respond in a moment of need to maintain a safe environment with resident oversight at all times. Director of Resident Wellness and Memory Care Coordinator will immediately review resident support plans for those within the memory care neighborhood; accounting for oversight, assistance, care needs (involving activities of daily living, and mobility needs) to ensure that staffing continues to meet regulatory requirements, and that resident supervision needs for our memory care residents are maintained at all times.

In the event of an emergency that occurs on the night shift (11p-7a), emergency management by the nurse or lead medication technician on duty can be sought from the 2nd/3rd floors to assist while maintaining safety for others in the community during a time of a temporary emergent need. Reinforcement of standards of practice will be provided to staff who frequently work the night shift positions on fire drill response during these times by August 15, 2020. Immediate implementation of overnight fire drill will be initiated by Executive Director to determine staffing knowledge on fire drill evacuation safety and shelter in place during an emergency.

a. *Changing practice?*

*Education to staff to seek out the assistance of others within the community to assist in temporary times of need.
Education to be provided by August 15, 2020*

b. Teaching or Training?

Teaching will be provided to staff on techniques of additional staff utilization available throughout the community. Education of Maintenance Technician on their role in precepting fire drills at any time; their role is for monitoring and management of time to respond only, not to assist other staff in movement of residents. Review of fire drill documentation ensuring compliance with staffing and time standards will be reviewed by Executive Operations Officer. Teaching and documentation review to be provided/completed by August 15, 2020.

c. On-going Monitoring?

Executive Operations Officer will ensure that training is complete and that all staff are aware of safe practices, and available options of additional staffing support in times of need.

7. Designated position responsible and specify target date for correction.

Executive Operations Officer will be responsible for education to staff. Target date for correction is August 15, 2020.

Completion Date: 08/15/2020

60a - Staff/Support Plan *(continued)***Document Submission - 08/19/2020****Implemented**

Last staff member completed follow up to training on 8/18/2020. All but one staff completed education by August 15, 2020. Documents attached for staff sign off, and updated POC includes specifics on who are trained ancillary. Fire Drill implemented and previous drill documentation reviewed by August 18, 2020.