Department of Human Services
Bureau of Human Service Licensing

November 2, 2022

DUNWOODY VILLAGE INC
3500 WEST CHESTER PIKE
ATTN:PERSONAL CARE SERVICES
NEWTOWN SQUARE, PA, 19073

RE: DUNWOODY VILLAGE
3500 WEST CHESTER PIKE
NEWTOWN SQUARE, PA, 19073
LICENSE/COC#: 14525

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/03/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
Mia Johnson

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services

Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *DUNWOODY VILLAGE* **License #**: *14525* **License Expiration**: *12/22/2022*

Address: *3500 WEST CHESTER PIKE, NEWTOWN SQUARE, PA 19073*

County: *DELAWARE* **Region**: *SOUTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *DUNWOODY VILLAGE INC*

Address: *3500 WEST CHESTER PIKE, ATTN:PERSONAL CARE SERVICES, NEWTOWN SQUARE, PA, 19073*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/30/2002* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *92* **Waking Staff**: *69*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *10/03/2022*

Inspection Dates and Department Representative

10/03/2022 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *74*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Cedars West* **Capacity**: *20* **Residents Served**: *17*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

10/03/2022 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/23/2022*

Inspections / Reviews *(continued)*

11/01/2022 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/02/2022*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/04/2022*

11/02/2022 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/02/2022*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] staff person A stated to resident 1 "If you fall again I'm just going to leave you here". Staff person A then stated to resident 1, "what are you trying to do, Kill yourself". This incident was reported to staff person B on [redacted] However, this allegation of abuse was not reported to Older Adult Protective Services.

POC Submission ***Accept (MJ - 11/01/2022)***

The Allegation of this verbal abuse was called into Adult Protective Services and they received the call immediately after it was discovered. However, the ACT 70 form was mistakenly not submitted. We are requiring education of all Personal Care Staff. Education (required) about submitting the Act 70 form is being offered 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31. Required attendance is being recorded.

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)

15b - Supervisor Plan

2. Requirements

2600.
15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] staff person A stated to resident 1 "If you fall again I'm just going to leave you here". Staff person A then stated to resident 1, "what are you trying to do, Kill yourself". This incident was reported to staff person B on [redacted] The home did not suspend or develop a plan of supervision for staff person A. Staff person A remained on the schedule.

POC Submission ***Accept (MJ - 11/01/2022)***

When the allegation of this behavior was made, it wasn't clear who the staff person was. The resident kept calling the staff member who allegedly made statements to the resident by a different name. We switched assignments even when it was not clear who the staff person was. We wanted to make certain the staff who was working with the resident wasn't part of the allegation to ensure that the staff person wasn't working with the resident who reported the abuse. When we discovered who the staff person that the resident was talking about, we continued with the different assignment, as there was no contact with the resident by the alleged staff person. In the future we will take the alleged staff off of the schedule pending the outcome of an investigation. We will ensure that the staff person will be educated, supervised and relocated only if it is safe to bring the staff back to service. We in no way would ever knowingly place a resident in harms way. All staff are being educated about this situation. Education is required and is being offered 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31. Attendance is being recorded.

15b - Supervisor Plan *(continued)*

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)

15c - Supervision

3. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] staff person A stated to resident 1 "If you fall again I'm just going to leave you here". Staff person A then stated to resident 1, "what are you trying to do, Kill yourself". This incident was reported to staff person B on [redacted] The home did not suspend staff person A. The home did not develop a plan of supervision and have the plan approved by the Department.

POC Submission ***Accept (MJ - 11/01/2022)***

We will have any and all alleged staff taken off of the schedule pending the results of an investigation. If it is deemed safe to return the staff person to service, the staff will have a different assignment and will be educated and closely supervised. All situations will be discussed and made with the home's Human Resources office being involved. The SE Regional DHS office will be informed of our actions and plans regarding assignments, supervision and disposition regarding safety for the resident. We will ensure that the staff person will be educated, supervised and relocated only if it is safe to bring the staff back to service. We in no way would ever knowingly place a resident in harms way. All staff are being educated about this situation. Education is required and is being offered 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31. Attendance is being recorded.

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [redacted] resident 1 was in their room and asked staff person A to assist them to the bathroom. Staff person A began to assist resident 1 to the bathroom while walking to the bathroom resident 1 look up lost [redacted] balance and almost fell. Staff person A prevented the resident from falling. Staff person A then stated to resident 1, "if you fall again, I am not going to pick you up". Staff person A told the resident to do one thing at a time. Staff person A stated to resident 1, "what are you trying to do, Kill yourself". Resident 1 was stunned and shocked to hear this from staff person A. Resident 1 was scared and worried of what would happen if they fell and were seriously injured and staff person A would just leave them there.

42c - Treatment of Residents *(continued)*

POC Submission ***Accept (MJ - 11/01/2022)***

All residents are treated with dignity and respect. We will assure that safety, care, dignity and respect are foremost in all we do to care and support the residents of Dunwoody Village Personal Care. Had it been clear as to who the allegations were about and knowledge of what was specifically alleged, we would always act with the welfare of the resident in mind and their dignity and respect is paramount. We are providing education to all staff regarding this situation and how we can provide for the best care and treatment possible. Education is required and is being offered 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31. We have currently begun a transformative education process featuring the Montessori methods and philosophy for older adults at Dunwoody Village Personal Care. Dignity , respect and overall quality of life are at the forefront of providing Montessori education.

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)

53c - Administrator Duties

5. Requirements

2600.
53.c. The administrator shall be responsible for the administration and management of the home, including the health, safety and well-being of the residents, implementation of policies and procedures and compliance with this chapter.

Description of Violation

Staff person B admitted to not knowing that the Act 70 form needed to be sent to the Older Adult Protective services agency. Staff person B was unaware there was a form that had to be sent. Staff person B also states that staff person A remained on the schedule and was not placed on leave until the investigation was completed in its entirety.

POC Submission ***Accept (MJ - 11/01/2022)***

The information from the Act 70 form was telephoned to Adult Protective Services on the date the incident was discovered and it had never been asked for by Adult protective Services or DHS in the past. However, Act 70 forms are readily available and will be completed and sent to both DHS and Adult Protective services . This was a mistake based on the form never being clearly required or requested in the past. All staff are now being educated on the use of the Act 70 Form and the importance of abuse allegations being reported immediately upon discovery and documented on the required reportable forms. All Personal Care Staff education on the Act 70 form and the DHS reportable form is required and is being offered 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31.

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)

252 - Record Content

6. Requirements

2600.
252. Content of Resident Records - Each resident’s record must include the following information:

1. Name, gender, admission date, birth date and Social Security number.
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.
4. Language or means of communication spoken or used by the resident.

252 - Record Content *(continued)*

5. The name, address, telephone number and relationship of a designated person to be contacted in case of an emergency.
6. The name, address and telephone number of the resident's physician or source of health care.
7. The current and previous 2 years' physician's examination reports, including copies of the medical evaluation forms.
8. A list of prescribed medications, OTC medications and CAM.
9. Dietary restrictions.
10. A record of incident reports for the individual resident.
11. A list of allergies.
12. The documentation of health care services and orders, including orders for the services of visiting nurse or home health agencies.
13. The preadmission screening, initial intake assessment and the most current version of the annual assessment.
14. A support plan.
15. Applicable court order, if any.
16. The resident's medical insurance information.
17. The date of entrance into the home, relocations and discharges, including the transfer of the resident to other homes owned by the same legal entity.
18. An inventory of the resident's personal property as voluntarily declared by the resident upon admission and voluntarily updated.
19. An inventory of the resident's property entrusted to the administrator for safekeeping.
20. The financial records of residents receiving assistance with financial management.
21. The reason for termination of services or transfer of the resident, the date of transfer and the destination.
22. Copies of transfer and discharge summaries from hospitals, if available.
23. If the resident dies in the home, a copy of the official death certificate.
24. Signed notification of rights, grievance procedures and applicable consent to treatment protections specified in § 2600.41 (relating to notification of rights and complaint procedures).
25. A copy of the resident-home contract.
26. A termination notice, if any.

Description of Violation

Resident 1's record does not include the reportable incident fron[redacted]volving resident 1 and staff person A.

POC Submission ***Accept (MJ - 11/01/2022)***

The reportable incident was presented along with the chart documentation. Although the incident report was offered separately from the chart, it was completed and sent to the regional DHS within 24 hours of when the incident was reported. The incident report is now part of the medical record and resides on the chart and was always available. It was given to the DHS inspector separately from the chart. In the future, the incident report will not be removed from the chart and will remain on the chart in case of any medical record inspection or audit. Education is required and is being offered to personal care staff on 10/13, 10/17, 10/19,, 10/24, 10/26, 10/27 and 10/31. Not removing the incident report from the chart is part of this staff education.

Licensee's Plan Completion Date: *10/31/2022*

Implemented (MJ - 11/02/2022)