

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

June 13, 2023

[REDACTED], ADMINISTRATOR
JUNIPER VILLAGE AT STATE COLLEGE OPERATIONS I LLC
[REDACTED]

RE: JUNIPER VILLAGE AT BROOKLINE -
WELLSPRING MEMORY CARE
610 WEST WHITEHALL ROAD
STATE COLLEGE, PA, 16801
LICENSE/COC#: 24130

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/02/2023 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,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: JUNIPER VILLAGE AT BROOKLINE - WELLSRING MEMORY CARE **License #:** 24130 **License Expiration:** 05/15/2023

Address: 610 WEST WHITEHALL ROAD, STATE COLLEGE, PA 16801

County: CENTRE **Region:** NORTHEAST

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: JUNIPER VILLAGE AT STATE COLLEGE OPERATIONS I LLC

Address: [REDACTED]

Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 66 **Waking Staff:** 50

Inspection Information

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

Reason: Complaint, Incident **Exit Conference Date:** 03/14/2023

Inspection Dates and Department Representative

02/02/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 38 **Residents Served:** 33

Secured Dementia Care Unit

In Home: Yes **Area:** Entire building **Capacity:** 38 **Residents Served:** 38

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 33

Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0

Have Mobility Need: 33 **Have Physical Disability:** 0

Inspections / Reviews

02/02/2023 Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 03/24/2023

04/07/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 06/08/2023

Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/13/2023

Inspections / Reviews *(continued)*

06/06/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 06/08/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 06/12/2023

06/13/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 06/08/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

While on-site at the facility on 2/2/23, an agent of the Department requested access to the results of the home's internal investigation regarding Resident #1's unwitnessed and unreported fall on [REDACTED]. The facility's Administrator refused to provide access to these records after multiple requests were made by the agent of the Department.

Plan of Correction

Directed [REDACTED] - 06/06/2023)

2600.16- 5a

The facility respectfully declines the issuance of this citation as it is not correct per the regulation nor RCG definition. The facility was in full compliance and provided the required resident records to the inspector as upon request. Specifically, the administrator provided the following records: Face-Sheet, Pre-Admission Screening, 2 most recent DME, 2 most recent Resident Assessment and Support Plan documents. Records are explicitly defined by the RCG Page 168 as follows:

2600.252 - 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.
- (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.

Therefore the provided information was in compliance with resident records per 55 Pa. Code Chapter 2600. Upon request, as both a courtesy and to support the investigation, the administrator also verbally shared the information detail of the quality assurance review statements of employees with the Inspector. It is noted quality assurance review statements are not defined in the aforementioned legal definition for resident records and are not part of the resident records.

The following plan of correction is provided for compliance purposes only and not as admission of any regulatory violation or care standard: ED and DOW reviewed the regulation and have been educated on the requirement to provide copies of the resident record upon request in a timely manner. ED will monitor for continued compliance.

5a1 DHS Access (continued)

Pursuant to 62 P.S. § 1016(a) (Right to enter and inspect), 55 Pa. Code § 2600.5(a)(1) (Access) and 55 Pa. Code § 20.34 (Access), the Administrator shall immediately ensure that agents of the Department have access to the home, records, and residents upon request. The Administrator will immediately designate a direct care staff person to act as designee when the administrator is not present in the home. The designee will have access to all staff and resident records and provide immediate access to agents of the Department, upon request. The staff schedule will indicate who is acting as the administrator designee on all shifts. The Administrator will submit the staff schedule to the Department, to include the names and phone numbers of all staff that worked on 7/17/22. The Administrator will submit to the Department all unredacted witness statements pertaining the incident that took place on 7/17/22 involving resident #1 as well as any documentation relating to the internal investigation of this incident. The administrator will submit the staff schedule with staff contact information, unredacted witness statements and any/all documentation related to the incident on 7/17/22 involving resident #1 to the Department's NE Regional office by 6/12/23.

Directed Completion Date: 06/12/2023

Implemented (█) - 06/13/2023

142a - Secure Medical Care

2. Requirements

2600.

142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Resident #1 experienced an unwitnessed fall on █, which was not reported by Staff Person A or Staff Person B, who attested to assisting Resident #1 when he/she was found on the floor. On █, Resident #1 was reported to have been witnessed "crying out in pain" every time █ was moved by staff during care. The home did not seek medical attention for Resident #1 until █ when a mobile x ray was performed. On █ Resident #1 was diagnosed with a left hip fracture and admitted to the hospital.

Plan of Correction

Accept (█) - 06/06/2023

142a.

The facility respectfully disagrees with the issuance of this citation as it is incorrect as written in which it indicates a first hand report from staff persons whom were not interviewed by the inspector. These staff persons were not present at inspection and were not interviewed by the inspector. At no time was the facility made aware of description of the behaviors per the citation to allow for actionable securing of medical care. Had the facility been made aware of this behavior, reasonable and timely action would have been completed as required to provide for the care and wellbeing of the resident.

The facility was in compliance per regulation as evidenced by the following: The resident was documented in progress notes that were shared with the Department to be functioning without change in condition or symptoms from 7/17/22 through 7/22/22. On 7/21/22 nursing documentation in a progress note indicates an evaluation of status without change. There is also notation on a hospital discharge summary (secured by the inspector) which corroborates this timeline. It is noted this resident has a positive history of major back surgery which may result in baseline of mild to moderate generalized discomfort but otherwise self ambulates as needed and is able to self assist with some ADLS.

- Per nursing progress notes on 7/22/23 nursing progress note indicates change in status was observed and

142a Secure Medical Care (continued)

reported timely to both the pcp and family. Both parties agreed to obtain on site mobile x ray which was ordered 7/22/22 and completed 7/23/22 in am. It's noted the facility has no care or control of scheduling or timing of x ray services.

- Resident dx was confirmed and was sent to MNMC for evaluation. The aforementioned resident record progress notes evidence there was no observance of change in status until 7/22/22 which was reported timely including reasonable intervention initiated by the home.

The following plan of correction is provided for compliance purposes only and not as admission of any regulatory violation or care standard: Education was provided to assigned care associates on change in status evaluation and reporting by the DOW and ED as evidenced in the attached documentation. ED/DOW or designee will audit submitted change of condition progress notes.

Licensee's Proposed Overall Completion Date: 04/10/2023

Implemented [REDACTED] - 06/13/2023)