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

April 28, 2023

[redacted], ADMINISTRATOR
LITTLE WALKER HOLDINGS LLC
[redacted]

RE: TWIN CEDAR SENIOR LIVING
364 LITTLE WALKER ROAD
SHOHOLA, PA, 18458
LICENSE/COC#: 22850

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/24/2023, 03/27/2023 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *TWIN CEDAR SENIOR LIVING* **License #**: *22850* **License Expiration**: *12/20/2023*

Address: *364 LITTLE WALKER ROAD, SHOHOLA, PA 18458*

County: *PIKE* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *LITTLE WALKER HOLDINGS LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/08/1995* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *30* **Waking Staff**: *23*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/27/2023*

Inspection Dates and Department Representative

03/24/2023 - Off-Site: [redacted]
03/27/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *37* **Residents Served**: *27*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *27*

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

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

03/24/2023 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/23/2023*

Inspections / Reviews *(continued)*

04/26/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/26/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/01/2023*

04/28/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/26/2023*

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

42b - Abuse

1. Requirements

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 3/24/23 the home conducted a fire drill. During the fire drill Direct care staff member A pushed Resident #1 out of the building while the resident sat on the seat of the residents wheeled rollator walker. While in the parking lot the resident fell backwards off the seat of the walker and sustained a fractured right ankle as a result of the fall.

Plan of Correction ***Accept [redacted] - 04/26/2023)***

On 3/24/23 Twin Cedar conducted an overnight fire drill in the early hours of the morning as per DHS regulation and facility policy. During the drill, which was a full building evacuation, resident #1 became fatigued and stated to staff that she could no longer walk and took a seat on her rollator walker in the evacuation route. As per the homes policy, staff are to treat every drill as though there is real danger so that staff are fully prepared in the event of a try emergency requiring the evacuation of the community. The staff person conducting the drill made a quick decision to assist the resident to safety by pushing her while seated on the rollator walker with the intention of getting her to safety and going back to assist other residents to safety as well in a timely manner. The safety of the residents was of top concern and priority during the evacuation. Despite the best intentions of staff, once outside, the rollator tipped backwards causing the resident to fall. Staff responded immediately to the resident to assess her and sent her out for further evaluation. All residents were evacuated in a timely manner including resident #1. While we respect the agency and their decision to designate this violation as they did, we strongly disagree with the designation as this was an active unannounced full evacuation fire drill which our staff acted quickly to unblock an evacuation route to ensure resident #1 and all residents were evacuated accordingly. This was an unfortunate accident with the well being of Resident #1 and all residents in mind and in our opinion does not fall under the allotted designation, description or definition of the 42b violation.
Following the incident, on 4/6/23 all staff were re-educated on proper evacuation techniques and transfers during emergency situations, as well as resident rights and physical accommodations and equipment to ensure their understanding. Additionally, all staff is in process of being trained on the potential for a residents change of mental or physical status and safe ways to respond during an evacuation. Moving forward, all staff will be trained on these topics annually during required annual trainings, and briefed on these trainings at the time of each drill. New hires will be trained on these topics during onboarding, and then again during the above mentioned schedule. Administrator will be responsible for conducting the training and ensuring the completion by all staff. Administrator to complete monthly training audits to ensure completion. Initial re-training occurred on 4/6/23 and audits to occur monthly thereafter to ensure compliance.

Licensee's Proposed Overall Completion Date: *04/23/2023*

Implemented ([redacted] - 04/28/2023)

81a - Accomodation

2. Requirements

2600.
81.a. The home shall provide or arrange for physical site accommodations and equipment necessary to meet the health and safety needs of a resident with a disability and to allow safe movement within the home and exiting from the home.

81a Accomodation *(continued)*

Description of Violation

On 3/24/23 the home conducted a fire drill. During the fire drill Direct care staff member A pushed Resident #1 out of the building while the resident sat on the seat of the residents wheeled rollator walker. While in the parking lot the resident fell backwards off the seat of the walker and sustained a fractured right ankle as a result of the fall. The home failed to arrange Resident #1 with the proper equipment to allow safe movement within the home and exiting from the home.

Plan of Correction ***Accept ([redacted] - 04/26/2023)***

On 3/24/23 Twin Cedar conducted an overnight fire drill in the early hours of the morning as per DHS regulation and facility policy. During the drill, which was a full building evacuation, resident #1 became fatigued and stated to staff that she could no longer walk and took a seat on her rollator walker in the evacuation route. As per the homes policy, staff are to treat every drill as though there is real danger so that staff are fully prepared in the event of a try emergency requiring the evacuation of the community. The staff person conducting the drill made a quick decision to assist the resident to safety by pushing her while seated on the rollator walker with the intention of getting her to safety and going back to assist other residents to safety as well in a timely manner. The safety of the residents was of top concern and priority during the evacuation. Despite the best intentions of staff, once outside, the rollator tipped backwards causing the resident to fall. Staff responded immediately to the resident to assess her and sent her out for further evaluation. All residents were evacuated in a timely manner including resident #1. While we respect the agency and their decision to designate this violation as they did, we strongly disagree with the designation as this was an active unannounced full evacuation fire drill which our staff acted quickly to unblock an evacuation route to ensure resident #1 and all residents were evacuated accordingly. This was an unfortunate accident with the well being of Resident #1 and all residents in mind and in our opinion does not fall under the allotted designation, description or definition of the 42b violation.

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Licensee's Proposed Overall Completion Date: *04/23/2023*

Implemented ([redacted] - 04/28/2023)