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

May 1, 2023

[redacted]
RAPPS SENIOR CARE LLC
[redacted]

RE: WOODBRIDGE PLACE
1191 RAPPS DAM ROAD
PHOENIXVILLE, PA, 19460
LICENSE/COC#: 14359

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/12/2023 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: *WOODBRIDGE PLACE* **Licen e #**: *14359* **Licen e Expiration**: *10/08/2022*

Address: *1191 RAPPS DAM ROAD, PHOENIXVILLE, PA 19460*

County: *CHESTER* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *RAPPS SENIOR CARE LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *08/29/1996* **I ued By**: *Commonwealth of PA. L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *95* **Waking Staff**: *71*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *04/12/2023*

Inspection Dates and Department Representative

04/12/2023 On Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *61*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lilac Terrace* **Capacity**: *21* **Residents Served**: *17*

Hospice

Current Residents: *10*

Number of Residents Who:

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

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

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

04/12/2023 - Partial

Lead Inspector [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/27/2023*

04/28/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2023*

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

Inspections / Reviews *(continued)*

05/01/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/01/2023*

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]22, at [redacted] P.M., staff member A, the Administrator/Executive Director, contacted staff member B regarding staff member C's interactions with residents of the secured dementia care unit (Lilac Terrace). Staff member A was informed in an email dated [redacted] 2023 at [redacted] P.M., that staff member C was witnessed "...holding an arm of a resident forcing them in to the room...", and that staff C told other staff to "...lock one resident out of [redacted] room...". This allegation of abuse was not reported to the local area agency on aging until [redacted]/23 at [redacted] P.M. after discussion with an agent of the Department.

Plan of Correction ***Accept [redacted] - 04/28/2023)***

When: Resident abuse report, Act 13 was submitted while DHS representative was conducting inspection/investigation in the facility. Protective Services from Chester County were notified while the DHS representative was still in the facility.
Who: During the weekly walk-through of the facility the Executive Director will also be conducting review with the Wellness Department Staff to ensure that nothing arises regarding misconduct or possibility of abuse.
How: Review of weekly findings will be discussed during quarterly Quality Management reviews and reviews of Residents Rights will be discussed during the staff monthly meetings.

Licensee's Proposed Overall Completion Date: *04/27/2023*

Implemented [redacted] - 05/01/2023)

42b - Abuse

2. 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

Face-to-face interviews and written statements recount the following actions by staff member C as witnessed by other staff members;

- *Staff member C grabbed resident #1's arm and would drag them to their room.*
- *Staff member C would grab resident #2's arm and say let's go to your room. This happened on three different occasions.*
- *Staff member C would lock, or have staff lock, resident #2 out of [redacted] room to prevent the resident from going back to bed after meals.*
- *Staff member C's behavior and actions affected residents 1, 2 and 3 to the point where the residents would say to other staff members "I'm sorry" (Res 1#), "I'm not nice, I'll do better" (Res #2) and "I won't do that, I'm sorry" (Res #3)".*
- *Resident #3 would point at staff member C and say "[redacted] mean".*
- *Staff believe staff member C's actions negatively affected resident #1's mental status as well due to resident #1 now stating that "[redacted]ugly", "[redacted]should stop talking" and [redacted] doesn't want to get in trouble".*

42b - Abuse (continued)

These actions represent abuse through unreasonable confinement, deliberately causing mental anguish, deprivation by the personal care home staff persons of goods and services necessary to maintain physical or mental health and mistreatment of residents.

Plan of Correction ***Accept (- 04/28/2023)***

When: Upon learning of the misconduct, staff member C was immediately suspended while investigation continued. As a conclusion of the investigation staff member C's employment was dissolved.
Who: The training on resident abuse and resident rights began on April 17th and concluded on April 24th. The training was conducted by Tia Hovatter, MPH, NHA, ACC, CDP, CADDCT from Health Consultants Plus.
How: To ensure understanding of abuse and reporting of abuse, training/education was conducted dur ng several days in a group of up to six staff members. Additional review of Residents Rights will be addressed during mandatory monthly staff meetings.

Licensee's Proposed Overall Completion Date: *04/27/2023*

Implemented - 05/01/2023)

202 - Prohibitions

3. Requirements

2600.
202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompting, escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

On 04/12/23 face-to-face interviews were held with several staff. In those interviews, staff stated, on multiple occasions, they witnessed staff member C grab a resident by the arm and pull and/or push a resident to get them back to their room.

Plan of Correction ***Accept - 04/28/2023)***

When: Upon learning of the misconduct, staff member C was immediately suspended while investigation continued. As a conclusion of the investigation staff member C's employment was dissolved.
Who: The training on Regulation 2600.202 began on April 17th and concluded on April 24th. The training was conducted by , MPH, NHA, ACC, CDP, CADDCT from Health Consultants Plus.

202 - Prohibitions (continued)

How: To ensure understanding of Prohibitions (reg.2600.202) training/education was conducted during several days n a group of up to six staff members. Review of the regulation 2600.202 will be conducted during the Quality Management meeting.

Licensee's Proposed Overall Completion Date: *04/27/2023*

Implemented [redacted] - 05/01/2023)