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

February 19, 2025

[redacted]
DUNWOODY VILLAGE INC
[redacted]
ATTN:PERSONAL CARE SERVICES
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/16/2024 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: *DUNWOODY VILLAGE* **License #**: *14525* **License Expiration**: *12/22/2024*

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

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

Administrator

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

Legal Entity

Name: *DUNWOODY VILLAGE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *01/30/2022* **Issued By**: *L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *100* **Waking Staff**: *75*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *12/16/2024*

Inspection Dates and Department Representative

12/16/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *81* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Cedar West* **Capacity**: *20* **Residents Served**: *16*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *69*

Diagnosed with Mental Illness: *6*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *30*

Have Physical Disability: *0*

Inspections / Reviews

12/16/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/17/2025*

01/22/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/28/2025*

Inspections / Reviews *(continued)*

02/04/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *02/14/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *02/14/2025*

02/19/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/14/2025*

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

On [redacted] during the entrance conference, staff person A, the administrator, mentioned there is a video recording of the incident. An agent of the Department requested access to the video, and staff person A stated that it was not possible to provide a copy of the video as per corporate; this video was confidential, and it was an internal investigation due to the prohibition of recording inside the facility.

Plan of Correction ***Directed [redacted] - 02/04/2025)***

Dunwoody Village Personal Care would like to contest this violation based on the following reasons:

1. Upon request, inspector was granted immediate and complete access to the home, the resident and the resident records in full compliance with 55 Pa. Code 2600.5(a). The video is not a resident record as defined in 55 Pa. Code 2600.252.
2. When inspector requested access to the video, administrator arranged for video to be provided through the private duty aide who had recorded the video, who is not a Dunwoody Village employee.
3. Because there was a question about confidentiality, and the legality of sharing the video, the Administrator did not immediately provide a copy of the video (which the private duty aide sent to Dunwoody Village after the incident) but offered to provide it to the Department if requested via an administrative subpoena if the inspector was unable to secure the video from the private duty aide.
4. While video recording does occur inside the facility as evidenced by the signage throughout stating that video recording occurs, no audio recording occurs. Regardless, Dunwoody Village has no video recording taken by the facility that shows the incident, and the only video of the incident (although only partially captured) was taken by a 3rd party who was identified to the inspector, with an offer to request that she make herself available for an interview.

5. Dunwoody Village cooperated fully with the Department's investigation, and provided all resident records as defined in 55 Pa. Code 2600.252.

Proposed Overall Completion Date: 02/03/2025

Directed
Immediately: The administrator will develop a system of record keeping that ensures the agents of the Department, upon request have immediate access to all documentation pertaining to staff, the home and residents.
By 2/14/25: All management staff will be educated on providing access to agents of the Department in accordance with regulation 2600.5a1. Documentation of education will be kept. [redacted]

5a1 DHS Access *(continued)*

Directed Completion Date: *02/14/2025*

Implemented [redacted] - 02/19/2025)

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

On [redacted] at approximately 6:30 am, staff person B was observed by a private duty aide through a slightly opened door attempting to put something on resident [redacted] hand. The resident was sitting in their wheelchair and staff person B was sitting in front of them in a chair in the hallway of the secure dementia unit (SDCU). Staff person B was observed slapping the residents hand. The resident stated "don't hit me" in response staff person B said "I didn't hit you". Staff person B further stated "this is why nobody likes you". Approximately 10 15 minutes later the resident was heard speaking in a loud tone "stop it". Staff person B was then observed holding what appeared to be a crumpled up napkin or paper towel waving it in front of the residents face. Resident [redacted] has a diagnosis of macular degeneration, unqualified visual loss both eyes and hearing impaired.

Plan of Correction ***Directed [redacted] - 02/04/2025)***

1. Video recording taken by a private duty aid of staff person B on [redacted], at approximately 6:30 am, does NOT show the employee attempting to put something on resident [redacted] hand or staff person B slapping the residents hand, this allegation cannot be substantiated. The video also does NOT record or show the resident stating "don't hit me" or staff person B saying "I didn't hit you" or "this is why nobody likes you".

The video does show a recording of the resident stating "stop it" and staff person B was observed holding what appeared to be a crumpled up napkin or paper towel waving it in front of the residents face. Resident [redacted] has a diagnosis of [redacted], unqualified visual loss both eyes and hearing impaired.

2. Employee was terminated as a result of Dunwoody's internal investigation concluding that staff person B's behavior was disrespectful, insensitive and an inappropriate for a resident with a diagnosis of [redacted]
3. Memory Care Unit Manager will ensure resident [redacted] support plan is updated with resident specific behaviors and interventions .
4. All staff who work on the SDU will be trained by Memory Care Nurse Manager about specific approaches with resident [redacted] beginning 1/21/25 and will be completed by 1/31/25.
5. Charge nurses will make rounds 2 times per shift on the SDU and log if staff member(s) observed during rounds are appropriate or if there are concerns of abuse beginning 1/20/25 for 90 days.

Proposed Overall Completion Date: 02/03/2025

Directed

42b - Abuse (continued)

By 2/14/25: All direct care staff, ancillary staff persons, substitute personnel, volunteers and management staff including the administrator will receive training in abuse reporting and prevention and resident rights from a Department-approved outside source such as the Area Agency on Aging. Documentation of training will be kept.
By 2/14/25: All direct care staff, ancillary staff persons, substitute personnel, volunteers and management staff including the administrator will receive training in care of residents with dementia, cognitive, visual, and hearing impairments, the importance of understanding and meeting the needs of residents as described in support plans. Documentation of training will be kept.
Immediately: The administrator or designee will observe staff twice a shift for two months and once a shift thereafter to ensure staff are providing proper care to residents. [redacted]

Directed Completion Date: *02/14/2025*

Implemented [redacted] ***- 02/19/2025)***