



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [REDACTED]
Mailing Date: August 10, 2018

Mr. William I. Weisberg
Vice President
Green Ridge Personal Care LLC
26691 Richmond Road
Bedford Heights, Ohio 44146

RE: The Gardens of Green Ridge
2751 Boulevard Avenue
Scranton, Pennsylvania 18509
License #225160

Dear Mr. Weisberg:

As a result of the Department's Bureau of Human Services Licensing inspection on May 22, 2018 of the above facility, the violations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

Sincerely,

A handwritten signature in cursive script that reads "Anne Graziano".

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

LICENSING INSPECTION SUMMARY
Assisted Living Residences – 55 Pa.Code § 2800

ALR Name: The Gardens of Green Ridge		License Number: 225160
Address: 2751 Boulevard Ave Scranton, Pennsylvania 18509		County: Lackawanna
Administrator: Bayard Williams		
Legal Entity Name: Green Ridge Personal Care, LLC		
Legal Entity Address: 26691 Richmond Road Bedford Heights, OH 44146		
Certificate(s) of Occupancy: I-1 09/12/2013		
Type of Inspection: Partial		
Reason(s) for Inspection(s): Incident		
On-Site Inspections Dates and Department Representatives On-Site: 5/22/2018 Jason Harvey		
Off-Site Inspection Dates and Inspectors, if Applicable: NA		
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 74	Number of Residents who:	
Number of Residents Served: 48	Receive Supplemental Security Income: 0	
Secured Dementia Care Unit in Home: 16	Are 60 Years of Age or Older: 48	
Area:	Have Mental Illness: 0	
Secured Unit Capacity, if Applicable: 24	Have an Intellectual Disability: 0	
Number of Residents Served in Secured Dementia Care Unit, if applicable: 16	Have a Mobility Need: 20	
Number of Current Hospice Residents: 3	Have a Physical Disability: 0	
Number of Hospice Residents in past year: 8		

LICENSING INSPECTION SUMMARY
Assisted Living Residences – 55 Pa.Code § 2800

Regulation

2800.15(a) - The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.701 – 10225.707) and 6 Pa. Code §§ 15.21 – 15.27 (relating to reporting suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

Violation

The home did not notify the local Area Agency on Aging of an allegation of resident abuse that occurred on 4/1/2018 until 4/3/2018.

Plan of Correction

The proper Reporting documentation, and investigation took place at Residence, however after conclusion of files, it was then reported to Area Agency on Aging but not within Reporting guidelines.

Going forward, proper, and timely reporting procedures will be completed with Regulation 2800.15(a) **YES**

Resident Care Director and Executive Director will monitor and Report per 2800.15(a)

Printed Name and Title of Legal Entity Representative (Required on all pages)

Raymond Williams Executive Director

Signature of Legal Entity Representative (Required on all pages)

[Signature] ED

Date 7/06/2018

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The above plan of correction is approved as of 7-25-18
(Date)

The above plan of correction was approved by [Signature]
(Initials)

Plan of correction implementation status as of 7-25-18:
(Date)

- Fully Implemented
- Partially Implemented – Adequate Progress
- Partially Implemented – Inadequate Progress
- Not Implemented

LICENSING INSPECTION SUMMARY
Assisted Living Residences – 55 Pa.Code § 2800

Regulation 2800.16(c) - The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. The residence shall immediately report the incident or condition to the resident's family and the resident's designated person. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).
Violation The home did not notify the Department of an allegation of resident abuse that occurred on 4/1/2018 until 4/3/2018
Plan of Correction Proper Reporting documentation and Investigation took place at Residence first, then after conclusion of facts it was then reported to the Department of Assisted Living, but not within Reporting Guidelines. Going forward, proper and timely Reporting Procedures will be completed with Regulation 2800.16(c). Resident Care Director and Executive Director will monitor and Report per 2800.16(c). Administrator will also ensure the home has a process in place to make timely incident reports at night, on the weekends, and on holidays. <i>CP</i>

Printed Name and Title of Legal Entity Representative (Required on all pages) <i>Donald Williams Executive Director</i>	
Signature of Legal Entity Representative (Required on all pages) 	Date 7/06/2018
DEPARTMENT USE ONLY – HOMES MAY NOT WRITE BELOW THIS LINE!	
The above plan of correction is approved as of <u>7-25-18</u> (Date)	Plan of correction implementation status as of <u>7-25-18</u> (Date)
The above plan of correction was approved by (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented – Adequate Progress <input type="checkbox"/> Partially Implemented – Inadequate Progress <input type="checkbox"/> Not Implemented

LICENSING INSPECTION SUMMARY
Assisted Living Residences – 55 Pa.Code § 2800

Regulation

2800.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. A resident must be free from mental, physical, and sexual abuse and exploitation, neglect, financial exploitation and involuntary seclusion.

Violation

On 4/1/2018 at approximately 6:00am staff person A tried to provide care to an agitated resident #1. Resident #1, who is immobile, grabbed staff person A's scrubs in the stomach area. Staff person A attempted to remove resident #1's hands by pulling the resident's arm back towards the resident from the wrist area to the elbow to free the resident's hands. This maneuver caused a skin tear to resident #1's both wrists. Resident #1 had dark purple bruising from the resident's mid forearm to the resident's wrist.

Plan of Correction

After documentation and thorough investigation was completed, Staff Person A went in to complete care on Resident # 1. Resident # 1 became anxious. Staff Person A continued to provide complete care. Resident # 1 began grabbing Staff Person A in the stomach area, Staff person A began freeing himself from Resident # 1. In doing so, resulted in skin tears as noted on Resident #1.

Additional training in OARSA was completed with staff. Going forward continued training in OARSA, along with noted items in 2800.42(b), along with proper care techniques will continue to be trained.

Resident Care Director and Executive Director will continue to oversee and train per annual training plan and additionally as needed.

Printed Name and Title of Legal Entity Representative (Required on all pages)

Donna Williams Executive Director

Signature of Legal Entity Representative (Required on all pages)

Date

7/06/2018

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The above plan of correction is approved as of 7-25-18
(Date)

Plan of correction implementation status as of 7-25-18
(Date)

The above plan of correction was approved by [Signature]
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- Partially Implemented – Inadequate Progress
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