

MAILING DATE: October 1, 2018

Ms. Nancy Posey, Acting Assisted Living Administrator Spiritrust Lutheran 1802 Folkemer Circle York, Pennsylvania 17404

RE: Spiritrust Lutheran the Village at

Sprenkle Drive Certificate # 332360

Dear Ms. Posey:

As a result of the Department's Bureau of Human Services Licensing inspection on September 17, 2018 of the above facility, the violations with 55 Pa.Code Ch. 2800 (relating to Assisted Living Residences) 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,

Brett Swanger

Human Services Licensing Supervisor

Enclosure Licensing Inspection Summary

Assisted Living Residences – 55 Pa.Code § 2800

PCH Name: SPIRITRUST LUTHERAN - THE VILLAGE AT SPRENKLE DRIV	License Number: 332360			
Address: 1802 FOLKEMER CIRCLE YORK, PENNSYLVANIA 17404		County: YORK		
Administrator: NANCY POSEY				
Legal Entity Name: SPIRITRUST LUTHERAN	ē			
Legal Entity Address: 1802 FOLKEMER CIRCLE YORK, PENNSYLVANIA 17404				
Certificate(s) of Occupancy: 12; 9/12/2014 MANCHESTER TOWNSHIP 12: 2/5/2016 MANCHESTER TOWNSHIP				
Type of Inspection: PARTIAL				
Reason(s) for Inspection(s): INCIDENT				
On-Site Inspections Dates and Department Representatives On-Site: 9/17/2018				
Off-Site Inspection Dates and Inspectors, if Applicable:				
Resident Demographic Data as of Inspection Dates				
Licensed Capacity: 56	Number of Residents who:			
Number of Residents Served: 50	Receive Supplemental Security	Income: 0		
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 5	50		
Area: Pin Oak	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: 23	Have a Mobility Need: 25			
Number of Current Hospice Residents: 0	Have a Physical Disability: 0			
Number of Hospice Residents in past year: 1				

Assisted Living Residences - 55 Pa.Code § 2800

Regulation

2800.42(c): A resident shall be treated with dignity and res	pect.
Violation: On 9/2/2018, Staff Person A insisted that Resident 1 go to that he/she did not need to use the bathroom at that time chair to a wheelchair without calling for additional staff to that the resident was unable to be transferred by only one Staff Person A pushed the wheel chair fast and Resident 1's Person A was again rough when transferring Resident 1 fro described being pushed by the staff member during transfer off the chair. This was the position in which Resident 1 was Resident 1 was not treated with dignity and respect by Staff	Staff Person A proceeded to transfer Resident 1 from a assist even though Resident 1 was telling Staff Person A staff person due to Resident 1's weakness at that time. It is arm was hit on the way into the bathroom. Staff om the wheelchair back into the chair. Resident 1 fer and landing with only half of his/her body on and half its found by other staff members. During this incident,
Plan of Correction:	
Refer to page 2A	
Printed Name and Title of Legal Entity Representative (Required on all pag	Bes), ALA
Signature of Legal Entity Representative (Required on all pages)) UN ALA Date 9-27-2018
	MAY NOT WRITE BELOW THIS LINE!
The above plan of correction is approved as of10/1/18(Date)	Plan of correction implementation status as of10/1/18: □ Fully Implemented
The above plan of correction was approved by $___BAS___$.	XPartially Implemented – Adequate Progress

(Initials)

□ Partially Implemented – Inadequate Progress

Not Implemented

Spiritrust Lutheran The Village at Spenkle Drive September 26, 2018 Certificate # 332360 Nancy Posey Acting Assisted Living Administrator

100000000000000000000000000000000000000	e concern as ed on violation report	
1.	Why is the regulation important?	2800.42(c) The regulation is important because it ensures that a resident shall be treated with dignity and respect.
2.	How was the regulation violated?	On 9/2/2018, Staff Person A insisted that Resident 1 go to the bathroom despite Resident 1 telling Staff Person A that he did not need to use the bathroom at that time. Staff Person A proceeded to transfer Resident 1 from a chair to a wheelchair without calling for additional staff to assist even though Resident 1 was telling Staff person A that the resident was unable to be transferred by only one staff person due to Resident 1's weakness at that time. Staff Person A pushed the wheel chair fast and Resident 1's arm hit on the way into the bathroom. Staff Person A was again being rough when transferring Resident 1 from the wheelchair back into the chair. Resident 1 described being pushed by the staff member during transfer and landing with only half of his body on and half off the chair. This was the position in which Resident 1 was found by other staff members. During this incident, Resident 1 was not treated with dignity and respect by Staff Person A.
3.	What caused the violation?	Staff Person A did not treat Resident 1 with dignity and respect by not listening to him and his wishes when he was explaining to her about his care needs when she was caring for him.
4.	What can be done right away to fix the violation?	The LPN immediately made sure that Resident 1 was safe, she then contacted the Director or Resident Care and the AL Administrator, Staff Person A was then asked to leave the unit until the Al Administrator arrived. Resident 1 was assessed and there was no harm/injury to him. Staff Person A was suspended pending an investigation. 911 was called per protocol as well as AAA. Officer Englar responded and interviewed the resident his POA was present during the interview.
5.	What can we do to prevent future violations?	Staff had an in-service on Residents Rights focusing on The Resident shall be treated with dignity and respect. Staff Person A was terminated 9/12/2018. AAA did a return visit to review the ASP and were satisfied with the corrections.
6.	Who will be responsible for preventing further violations?	The Assisted Living Administrator and Resident Care Coordinator will review Resident Rights at monthly staff meetings to ensure that all staff have an understanding of the Resident Rights. Reviews/audits will be brought to QM for review and additional recommendations.

Assisted Living Residences - 55 Pa.Code § 2800

Regulation: 2800.234(b)(1) The support plan and if applicable, the rehabilitation plan must identify the resident's physical, medical, social, cognitive and safety needs.		
Violation: The support plan finalized for Resident 1 on 8/15/2018, doe medical conditions of Resident 1: - CAD - Orthostatic Hypotension - Dry Scalp - Lower Back wound - Left Heel wound	s not identify the medical needs for the following	
Plan of Correction		
Refer to Page 3A		
Printed Name and Title of Legal Entity Representative (Required on all pages)	ALA	
Signature of Legal Entity Representative (Required on III pages)	URJ. ALA Date 9-27-2018	
DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!		
The above plan of correction is approved as of(Date)	Plan of correction implementation status as of10/1/18: □ Fully Implemented	
The above plan of correction was approved by \underline{BAS} (Initials)	X Partially Implemented – Adequate Progress □ Partially Implemented – Inadequate Progress □ Not Implemented	

Spiritrust Lutheran The Village at Spenkle Drive September 26, 2018 Certificate # 332360 Nancy Posey Acting Assisted Living Administrator

	e concern as	
describ	ed on violation report	
1.	Why is the regulation important?	2800.234(b)(1) This regulation is important because it ensures that the support plan and if applicable, the rehabilitation plan must identify the resident's physical, medical, social, cognitive and safety needs.
2.	How was the regulation violated?	The support plan finalized for Resident 1 on 8/15/2018, does not identify the medical needs for the following medical conditions of Resident 1: CAD, Orthostatic Hypotension, Dry Scalp, Lower Back wound, Left Heel Wound.
3.	What caused the violation?	The finalized support plan did not include the diagnoses that were on the signed ADME: CAD, Orthostatic Hypotension, Dry Scalp, Lower Back wound and L heel Wound.
4.	What can be done right away to fix the violation?	The ASP was updated with all signed diagnoses that were on the ADME and a notation was added giving more detail about the diagnoses to assist the direct care staff when caring for Resident 1. There was no harm to the resident.
5.	What can we do to prevent future violations?	The Director of Resident Care and Nursing will review the signed ADME/admission documentation, and all diagnoses will be added the ASP with notations added to give more detailed information to the direct care staff to help when caring for the Residents.
6.	Who will be responsible for preventing further violations?	The Director of Resident Care and Nursing will be responsible for ensuring that all signed ADMEs/admission documents will be reviewed against the ASP and the diagnosis will be added when identified. Reviews/audits will be brought to Quality Management for review and additional recommendations.

nancy Poery APN ALA 9-27-18

Assisted Living Residences – 55 Pa.Code § 2800

Regulation:
2800.234(c) The support plan and if applicable, the rehabilitation plan must identify the individual responsible to address the resident's needs.
Violation:
The support plan finalized on 8/15/2018 for Resident 1 does not identify the individual responsible to address the
resident's need for wound care.
Plan of Correction:
Refer to page 4A
Printed Name and Title of Legal Entity Representative (Required on all pages)

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Signature of Legal Entity Representative (Requ	ired on all pages)	Pope	y ypn	AUA	Date 9-27-	2018	
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The above plan of correction was approved by _	BAS (Initials)		and the transfer of the transf	•	ed – Adequate Proç ed – Inadequate Pr		
			□ Not Impl	emented			

Spiritrust Lutheran The Village at Spenkle Drive September 26, 2018 Certificate # 332360 Nancy Posey Acting Assisted Living Administrator

I	e concern as ed on violation report	
1.	Why is the regulation important?	2800.234(c)The regulation is important because it ensures that the support plan and if applicable, the rehabilitation plan must identify the individual responsible to address the resident's needs.
2.	How was the regulation violated?	The support plan finalized on 8/15/2018 for Resident 1 does not identify the individual responsible to address the resident's need for wound care.
3.	What caused the violation?	Resident 1 was admitted with lower back wound and Left heel wound, treatment was on the signed ADME medication list and treatment was put into QuickMAR, but it wasn't added to the ASP under the Medical Diagnoses and Dr. Gray, the Doctor responsible for the wound care, was not added under the Formal Support Section of the ASP.
4.	What can be done right away to fix the violation?	The lower back wound and Left heel wound, treatment and Dr. Gray were added to the ASP. There was no harm to the Resident.
5.	What can we do to prevent future violations?	The Director of Resident Care and Nursing will review the Formal Support section of the ASP to ensure that it will list all individuals responsible to address the resident's needs.
6.	Who will be responsible for preventing further violations?	The Director of Resident Care will audit the ASP's and coordinate with Nursing to ensure that all individuals responsible to address the resident's needs will be listed in Formal Support section of the ASP. Reviews/audits will be brought to Quality Management for review and additional recommendations.

Mancy Posey LAN, ALA 9-27-2018