



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**MAILING DATE: November 25, 2015**

Mr. Jeffrey S. Long, President/CEO  
St. Anne Home, Inc.  
Villa Angela at St. Anne Home  
685 Angela Drive  
Greensburg, Pennsylvania 15601

RE: Villa Angela at St. Anne Home  
# 428040

Dear Mr. Long:

As a result of the Department of Human Services' licensing inspection on September 11, 2015 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) 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. 2600 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jason Williams" with a stylized flourish at the end.

Jason Williams  
Regional Licensing Administrator

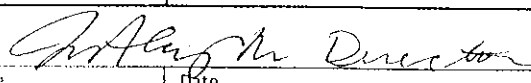
Enclosure  
Licensing Inspection Summary

**VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: VILLA ANGELA AT ST ANNE HOME		License Number: 42804
Address: 685 ANGELA DRIVE, GREENSBURG, PA 15601		County: Westmoreland
Administrator: Jennie Long		Region: WEST
Legal Entity Name: ST ANNE HOME INC		
Legal Entity Address: 685 ANGELA DRIVE, GREENSBURG, PA 15601		<b>RECEIVED</b>
<b>Certificate(s) of Occupancy</b> I-2 12/01/2010 City of Greensburg		NOV 17 2015 WEST REGION FIELD OFFICE Human Services Licensing
<b>Staffing Hours</b>		
Resident Support: N/A	Total Daily Staff: 51	Waking Staff: 38
Type of Inspection: Partial	BHA Docket Number: N/A	Notice: Unannounced
<b>Reason(s) for Inspection(s)</b>		
Incident		
<b>On-Site Inspections Dates and Department Representatives On-Site</b>		
09/11/2015: Park, Beth		
<b>Off-Site Inspection Dates and Inspectors, if Applicable</b>		
<b>Other Details</b>		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 54 Number of Residents Served: 43 Secured Dementia Care Unit in Home: No Area: Secured Dementia Unit Capacity, if Applicable: Number of Residents Served in Secured Dementia Care Unit, if applicable: Number of Current Hospice Residents: 2 Number of Hospice Residents in past year: 5	<b>Number of Residents who:</b> Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 43 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 8 Have a Physical Disability: 0	

Signature of Legal Entity Representative  
(Required on Every Page)

Printed Name and Title of Legal Entity Representative  
(Required on Every Page) Jennie R. Long, BSN, RN Director



Date  
November 17, 2015

Violation Report: 42804 - 09/11/2015 - Park, Beth  
PCH Name: VILLA ANGELA AT ST ANNE HOME

NOV 17 2015

1. REGULATION 55 Pa.Code §2600  
2600.42(c) - A resident shall be treated with dignity and respect.

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2a. DESCRIPTION OF VIOLATION

On 8/25/15 at dinner time, resident #1 was asked by resident #2 to take a cookie from the diningroom up to resident #2's room. Resident #1 agreed and, while transporting the cookie up to resident #2's room, was questioned repeatedly by staff person A as to why he/she had the cookie and accused resident #1 of taking resident #2's cookie. Resident #1 explained that he/she was taking it up to resident #2's room as a favor. Later that day, staff person A went to resident #1's room and asked resident #1 again where the cookie was and why he/she took it. Resident #1 cried after this incident and felt intimidated and treated like a child.

On 9/8/15 at approximately 4:30 AM, staff persons B and C were in resident #3's bedroom assisting resident #3 to the bathroom. After resident #3 was having difficulty standing up to transfer, staff person D was called in to assist. Resident #3 was still having difficulty standing up. Staff person D then told resident #3 that he/she would have to urinate in his/her incontinence brief and then have staff change it. Resident #3 felt humiliated by being asked to do this. Shortly thereafter, resident #3 was able to stand and use the bathroom with assistance from staff persons B and C.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Please see attached documentation. *Jennie R. Long*

See pages 2a + 2b of 2

Repeat Violation: No      Date(s) of Previous Violation(s):

Signature of Legal Entity Representative  
(Required on EVERY Page) *Jennie R. Long RN Director*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *Jennie R. Long BSN, RN, Director*      Date *November 17, 2015*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 11/25/15  
(Date)

Plan of correction implementation status as of 11/25/15  
(Date)

The above plan of correction was approved by *J.R.L.*  
(Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress *J.R.L.*
- Partially Implemented - Inadequate Progress
- Not Implemented

Plan of correction for Regulation §2600.42 (c) (see Page 2 of 2)

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NOV 17 2015  
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Human Services Licensing

2a. Incident involving Residents #1 and #2; Staff member (A).

❖ Immediate Actions:

- Resident #1's Family was notified.
- Human Resources/Corporate Compliance Officer for the facility was notified of the allegation.
- Immediate action was taken to remove the staff member (A) from the floor and put on indefinite leave without pay pending the completion of the investigation.
- Statements were obtained from Residents #1 and #2 and Staff member (A).
- Area Agency on Aging, Protective Services was notified September 10, 2015 at 1130.
- BHS was notified of the incident on September 10, 2015 at 1210.
- Prior to the investigation being completed, Staff member (A) tendered his/her resignation September 14, 2015 (Exhibit #1).

2b. Incident involving Resident #3; Staff members (B), (C) and (D).

❖ Immediate Actions:

- Resident #3's Family was notified.
- Human Resources/Corporate Compliance Officer for the facility was notified of the allegation.
- Immediate action was taken to remove the staff member (D) from the floor and put on indefinite leave without pay pending the completion of the investigation.
- Statements were obtained from Resident #3 and Staff members (B), (C) and (D).
- Area Agency on Aging, Protective Services was notified September 10, 2015 at 1118.
- BHS was notified of the incident on September 10, 2015 at 1210.
- After the investigation was completed, Staff member (D) was counseled on Resident Rights and Abuse. Staff member (D) also received a 5 day suspension without pay (Exhibit #2).

Signature of Legal Entity Representative (Required on Every Page)	
Printed Name and Title of Legal Entity Representative (Required on Every Page)	Date
Jennie R. Long, BSN, RN Director	November 17, 2015



Plan of correction for Regulation §2600.42 (c) (see Page 2 of 2)

❖ **Educational Opportunity for the Plan of Correction involving Regulation §2600.42 (c) to prevent a similar violation from occurring again.**

- On Monday, September 14, 2015, the Westmoreland County Ombudsman Program was contacted to schedule an in-service on Resident Rights.
- On October 13, 2015, from 1330 – 1500, [REDACTED], Westmoreland County Ombudsman, presented education for all Villa Angela Staff classifications (*Resident Care Coordinators, Resident Associates, Housekeeping, Administrative and Activities*), reviewing all of the Residents' Rights for §2600.42 (a) –(y), with an emphasis on Regulation §2600.42 (c) (**Exhibit #3**).

Signature of Legal Entity Representative <i>Jennie R. Long</i>	
<i>Jennie R. Long, BSN, RN Director</i>	
Printed Name and Title of Legal Entity Representative <b>Jennie R. Long, BSN, RN Director</b>	Date November 17, 2015