pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: February 1, 2017

Mr. Derek S. Culbertson, Administrator
Paramount Senior Living at Peters Township, LLC
240 Cedar Hill Drive
McMurray, Pennsylvania 15317

RE: Paramount Senior Living
at Peters Township
#443460

Dear Mr. Culbertson:

As a result of the Department of Human Services' licensing inspection on April 4, 2016, 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,

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

PCH Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP	**License Number:** 10443
Address: 240 CEDAR HILL DRIVE, MCMURRAY, PA 15317	**County:** Washington
Administrator: JANET STOCKHAUSEN	**Region:** WEST

Legal Entity Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP LLC

Legal Entity Address: 240 CEDAR HILL DRIVE, MCMURRAY, PA 15317

Certificate(s) of Occupancy

I-1 / I-2 / A-2
11/16/2011
Peters Twonship

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 127 **Waking Staff:** 95

Type of Inspection: Partial **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)

Complaint, Incident

On-Site Inspections Dates and Department Representatives On-Site

04/14/2016: Bartlett, Patricia; Georgoulis, Karen

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 109

Number of Residents Served: 92

Secured Dementia Care Unit in Home: Yes

Area: 2nd floor

Secured Dementia Unit Capacity, if Applicable: 35

Number of Residents Served in Secured Dementia Care Unit, if applicable: 25

Number of Current Hospice Residents: 13

Number of Hospice Residents in past year: 19

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 91

Have Mental Illness: 0

Have an Intellectual Disability: 0

Have a Mobility Need: 35

Have a Physical Disability: 0

Violation Report: 10443 - 04/14/2016 - Bartlett, Patricia
PCH Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP

1. REGULATION 55 Pa.Code §2600

2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION

On 3/28/16, at approximately 11:15 a.m., direct staff person A spoke rudely and yelled repeatedly at resident #1, "come here, come here," during the pre-shower preparation. Resident felt threatened and "treated like a dog". The home did not report this incident to the local Area Agency on Aging until 4/1/16 at approximately 1:40 p.m.

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.

See attached page.

SEE PAGE 2A OF 5

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

Signature of Legal Entity Representative (Required on EVERY Page) Derek Culbertson, NHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEREK CULBERTSON

Date 1/16/17

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

The above plan of correction is approved as of 1-18-17 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 1-18-17 (Date)

- ☐ Fully Implemented
- ☒ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of Correction for violation of 2600.15 (a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act.

Our plan to immediately correct the specific issue cited and ongoing plan to assure continued compliance includes:

On 3/28/16, a staff member reported to the administrator at that time that she heard another staff member talking loudly to a resident. The staff member did not know which resident it was because she was caring for a different resident in another room. The administrator questioned the staff member who was speaking loudly and the response from that staff member was that she "needs to speak loudly" to this particular resident "because [redacted] can't hear me." The resident did have a hearing deficit and often refused to wear [redacted] hearing aids. The administrator conducted an investigation into the incident, asking the resident [redacted] if [redacted] had been verbally abused. The resident responded with, "No. I am OK." At that time, the administrator felt that verbal abuse was unsubstantiated.

On the morning of 4/1/16, the facility received notification by the resident's daughter that an incident occurred on 3/28/16 with a staff member and her [redacted] She stated that her [redacted] felt threatened by the staff member. The administrator immediately followed up with the resident again and the resident then stated [redacted] felt he was "treated like a dog." At that time, the administrator felt that the situation had moved into a reportable incident. The facility then reported the incident to AAA on 4/1/16 at 1:40PM. The incident was also reported to DHS at 1:40PM. The staff member had been suspended immediately upon hearing the resident's second statement which countered the first. The suspension of the staff member occurred at 12:00 PM on [redacted]16. The staff member was then terminated on [redacted]16. She was removed from providing care as soon as the facility was made aware of the incident and did not work again with any residents during the suspension up to her termination of employment. All employees are in-serviced upon hire on Resident Rights, Abuse Reporting, and Resident Dignity and Respect. The employee in question received the in-services on [redacted]15. She would have received them again on her annual, but was let go prior to that date. Information regarding the decision to terminate the employee in question was sent to DHS in a follow up report on 4/2/17. The daughter, resident, and attending physician were notified of the decision to terminate the employee on [redacted]17. AAA was notified on [redacted]16 at 4:15 PM after the employee was able to be reached and informed of the termination of employment.

The plan to ensure the violation does not reoccur is as follows:

1.) Staff training: In the month of April, 2016 nursing employees were in-serviced by the Ombudsman, [redacted] on Resident Rights. The Director of Nursing in-serviced the staff on Abuse Reporting, Dignity, and Respect.

2.) Continued monitoring:

a. The violation will be added to the quality assurance reviews/meetings and the administrator or designee will interview three residents a month times three months to ensure that residents rights are being maintained and that they are being treated with dignity and respect.

b. The facility will conduct in-services on abuse and the importance of timely reporting, dignity and respect, protection of residents during investigation periods, and resident rights during the monthly staff meetings in February, March, and April 2017. We will request attendance from the Ombudsman to attend one or more of those meetings.

Dawn Culbertson, NHA — 1/16/17

Administrator — Date

RECEIVED
JAN 17 2017
WEST REGION FIELD OFFICE
Human Services Licensing

1-18-17

Violation Report: 10443 - 04/14/2016 - Bartlett, Patricia
PCH Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP

1. REGULATION 55 Pa.Code §2600

2600.15(b) - If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

2a. DESCRIPTION OF VIOLATION

On 3/28/16, at approximately 11:15 a.m., direct staff person A spoke rudely and yelled repeatedly at resident #1, "come here, come here," during the pre-shower preparation. Resident felt threatened and "treated like a dog". Direct care staff person A continued to provide unsupervised direct care services with resident #1 and with other residents on 3/28/16 from 11:15 a.m. to 3:00 p.m., on 3/29/16 from 7:00 a.m. to 3:00 p.m., and on 4/1/16 from 5:00 a.m. to 12:00 p.m..

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.

See attached page.

See PAGE 3A of 5

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

Signature of Legal Entity Representative (Required on EVERY Page) Derek Culbertson, NHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEREK CULBERTSON

Date 1/16/17

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The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 1-18-17 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress ✓
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of correction for violation of 2600.15 (b) – If there is an allegation of abuse involving a home's staff person, the home shall immediately develop or implement a plan of supervision or suspend the staff person involved in the alleged incident.

Our plan to immediately correct the specific issue cited and ongoing plan to assure continued compliance includes:

On 3/28/16, a staff member reported to the administrator at that time that she heard another staff member talking loudly to a resident. The staff member did not know which resident it was because she was caring for a different resident in another room. The administrator questioned the staff member who was speaking loudly and the response from that staff member was that she "needs to speak loudly" to this particular resident "because [redacted] can't hear me." The resident did have a hearing deficit and often refused to wear [redacted] hearing aids. The administrator conducted an investigation into the incident, asking the resident [redacted] if [redacted] had been verbally abused. The resident responded with, "No. I am OK." At that time, the administrator felt that verbal abuse was unsubstantiated.

On the morning of 4/1/16, the facility received notification by the resident's daughter that an incident occurred on 3/28/16 with a staff member and her [redacted] She stated that her [redacted] felt threatened by the staff member. The administrator immediately followed up with the resident again and the resident then stated [redacted] felt [redacted] was "treated like a dog." At that time, the administrator felt that the situation had moved into a reportable incident. The facility then reported the incident to AAA on 4/1/16 at 1:40PM. The incident was also reported to DHS at 1:40PM. The staff member had been suspended immediately upon hearing the resident's second statement which countered the first. The suspension of the staff member occurred at 12:00 PM on [redacted]16. The staff member was then terminated on [redacted]16. She was removed from providing care as soon as the facility was made aware of the incident and did not work again with any residents during the suspension up to her termination of employment. All employees are in-serviced upon hire on Resident Rights, Abuse Reporting, and Resident Dignity and Respect. The employee in question received the in-services on [redacted]15. She would have received them again on her annual, but was let go prior to that date. Information regarding the decision to terminate the employee in question was sent to DHS in a follow up report on [redacted]/17. The daughter, resident, and attending physician were notified of the decision to terminate the employee on [redacted]7. AAA was notified on [redacted]/16 at 4:15 PM after the employee was able to be reached and informed of the termination of employment.

The plan to ensure the violation does not reoccur is as follows:

1.) Staff training: In the month of April, 2016 nursing employees were in-serviced by the Ombudsman [redacted] on Resident Rights. The Director of Nursing in-serviced the staff on Abuse Reporting, Dignity, and Respect.

2.) Continued monitoring:

a. The violation will be added to the quality assurance reviews/meetings and the administrator or designee will interview three residents a month times three months to ensure that residents rights are being maintained and that they are being treated with dignity and respect.

b. The facility will conduct in-services on abuse and the importance of timely reporting, dignity and respect, protection of residents during investigation periods, and resident rights during the monthly staff meetings in February, March, and April 2017. We will request attendance from the Ombudsman to attend one or more of those meetings.

Dawn Culbertson, NHA
Administrator

1/16/17
Date

1-18-17 9

Violation Report: 10443 - 04/14/2016 - Bartlett, Patricia
PCH Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP

1. REGULATION 55 Pa.Code §2600

2600.16(c) - The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 3/28/16, at approximately 11:15 a.m., direct staff person A spoke rudely and yelled repeatedly at resident #1, "come here, come here," during the pre-shower preparation. Resident felt threatened and "treated like a dog". The home did not report this incident to the Department until 4/1/16 at approximately 1:40 p.m.

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.

See attached page.

See Page 4A of 5

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

Signature of Legal Entity Representative (Required on EVERY Page) Derek Culbertson, NHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEREK CULBERTSON

Date 1/16/17

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- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Plan of correction for violation of 2600.16 (c) – The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in section 2600.15 (relating to abuse reporting covered by law).

Our plan to immediately correct the specific issue cited and ongoing plan to assure continued compliance includes:

On 3/28/16, a staff member reported to the administrator at that time that she heard another staff member talking loudly to a resident. The staff member did not know which resident it was because she was caring for a different resident in another room. The administrator questioned the staff member who was speaking loudly and the response from that staff member was that she "needs to speak loudly" to this particular resident "because [redacted] can't hear me." The resident did have a hearing deficit and often refused to wear [redacted] hearing aids. The administrator conducted an investigation into the incident, asking the resident [redacted] if [redacted] had been verbally abused. The resident responded with, "No. I am OK." At that time, the administrator felt that verbal abuse was unsubstantiated.

On the morning of 4/1/16, the facility received notification by the resident's daughter that an incident occurred on 3/28/16 with a staff member and her [redacted] She stated that her [redacted] felt threatened by the staff member. The administrator immediately followed up with the resident again and the resident then stated [redacted] felt [redacted] was "treated like a dog." At that time, the administrator felt that the situation had moved into a reportable incident. The facility then reported the incident to AAA on 4/1/16 at 1:40PM. The incident was also reported to DHS at 1:40PM. The staff member had been suspended immediately upon hearing the resident's second statement which countered the first. The suspension of the staff member occurred at 12:00 PM on [redacted]16. The staff member was then terminated on [redacted]6. She was removed from providing care as soon as the facility was made aware of the incident and did not work again with any residents during the suspension up to her termination of employment. All employees are in-serviced upon hire on Resident Rights, Abuse Reporting, and Resident Dignity and Respect. The employee in question received the in-services on [redacted]15. She would have received them again on her annual, but was let go prior to that date. Information regarding the decision to terminate the employee in question was sent to DHS in a follow up report on [redacted]17. The daughter, resident, and attending physician were notified of the decision to terminate the employee on [redacted]17. AAA was notified on [redacted]16 at 4:15 PM after the employee was able to be reached and informed of the termination of employment.

The plan to ensure the violation does not reoccur is as follows:

1.) Staff training: In the month of April, 2016 nursing employees were in-serviced by the Ombudsman, [redacted] on Resident Rights. The Director of Nursing in-serviced the staff on Abuse Reporting, Dignity, and Respect.

2.) Continued monitoring:

a. The violation will be added to the quality assurance reviews/meetings and the administrator or designee will interview three residents a month times three months to ensure that residents rights are being maintained and that they are being treated with dignity and respect.

b. The facility will conduct in-services on abuse and the importance of timely reporting, dignity and respect, protection of residents during investigation periods, and resident rights during the monthly staff meetings in February, March, and April 2017. We will request attendance from the Ombudsman to attend one or more of those meetings.

Paul Gilbert, NHA
Administrator

1/16/17
Date

1-18-17

Violation Report: 10443 - 04/14/2016 - Bartlett, Patricia
PCH Name: PARAMOUNT SENIOR LIVING AT PETERS TOWNSHIP

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

2a. DESCRIPTION OF VIOLATION
On 3/28/16, at approximately 11:15 a.m., direct staff person A spoke rudely and yelled repeatedly at resident #1, "come here, come here," during the pre-shower preparation. Resident felt threatened and "treated like a dog".

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
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SEE PAGE 5A OF 5

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Signature of Legal Entity Representative (Required on EVERY Page) Derek Culbertson, NHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) DEREK CULBERTSON

Date 1/16/17

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The above plan of correction was approved by ____ (Initials)

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- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

Plan of correction for violation of 2600.42 (c) – A resident shall be treated with dignity and respect.

Our plan to immediately correct the specific issue cited and ongoing plan to assure continued compliance includes:

On 3/28/16, a staff member reported to the administrator at that time that she heard another staff member talking loudly to a resident. The staff member did not know which resident it was because she was caring for a different resident in another room. The administrator questioned the staff member who was speaking loudly and the response from that staff member was that she "needs to speak loudly" to this particular resident "because [redacted] can't hear me." The resident did have a hearing deficit and often refused to wear [redacted] hearing aids. The administrator conducted an investigation into the incident, asking the resident [redacted] if [redacted] had been verbally abused. The resident responded with, "No. I am OK." At that time, the administrator felt that verbal abuse was unsubstantiated.
On the morning of 4/1/16, the facility received notification by the resident's daughter that an incident occurred on 3/28/16 with a staff member and her [redacted] She stated that her [redacted] felt threatened by the staff member. The administrator immediately followed up with the resident again and the resident then stated [redacted] felt [redacted] was "treated like a dog." At that time, the administrator felt that the situation had moved into a reportable incident. The facility then reported the incident to AAA on 4/1/16 at 1:40PM. The incident was also reported to DHS at 1:40PM. The staff member had been suspended immediately upon hearing the resident's second statement which countered the first. The suspension of the staff member occurred at 12:00 PM on [redacted] 16. The staff member was then terminated on [redacted] 16. She was removed from providing care as soon as the facility was made aware of the incident and did not work again with any residents during the suspension up to her termination of employment. All employees are in-serviced upon hire on Resident Rights, Abuse Reporting, and Resident Dignity and Respect. The employee in question received the in-services on [redacted] 15. She would have received them again on her annual, but was let go prior to that date. Information regarding the decision to terminate the employee in question was sent to DHS in a follow up report on [redacted] 7. The daughter, resident, and attending physician were notified of the decision to terminate the employee on [redacted] /17. AAA was notified on [redacted] 16 at 4:15 PM after the employee was able to be reached and informed of the termination of employment.

The plan to ensure the violation does not reoccur is as follows:
1.) Staff training: In the month of April, 2016 nursing employees were in-serviced by the Ombudsman, [redacted] on Resident Rights. The Director of Nursing in-serviced the staff on Abuse Reporting, Dignity, and Respect.
2.) Continued monitoring:

a. The violation will be added to the quality assurance reviews/meetings and the administrator or designee will interview three residents a month times three months to ensure that residents rights are being maintained and that they are being treated with dignity and respect.

b. The facility will conduct in-services on abuse and the importance of timely reporting, dignity and respect, protection of residents during investigation periods, and resident rights during the monthly staff meetings in February, March, and April 2017. We will request attendance from the Ombudsman to attend one or more of those meetings.

Dawn Gilbert, NHA
Administrator

1/16/17
Date

1-18-17