pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: December 27, 2018

Mr. Ronald P. Buterbaugh
NHA
Senior Choice, Inc.
495 West Patriot Street
Somerset, Pennsylvania 15501

RE: The Patriot A Choice Community
Certificate #: 321360

Dear Mr. Buterbaugh:

As a result of the Department's Bureau of Human Services Licensing inspection on October 26, 2018 of the above facility, a violation with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary was found.

The violation 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,

Gloria Emick

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

PCH Name: THE PATRIOT A CHOICE COMMUNITY	**License Number:** 32136
Address: 495 WEST PATRIOT STREET, SOMERSET, PA 15501	**County:** Somerset
Administrator: Lori Fisher	**Region:** CENTRAL
Legal Entity Name: SENIOR CHOICE INC	
Legal Entity Address: 495 WEST PATRIOT STREET, SOMERSET, PA 15501	

Certificate(s) of Occupancy
C-1
09/11/1990
DOH

Staffing Hours

Resident Support: 0	**Total Daily Staff:** 58	**Waking Staff:** 44
Type of Inspection: Partial	**BHA Docket Number:**	**Notice:** Unannounced

Reason(s) for Inspection(s)
Incident

On-Site Inspections Dates and Department Representatives On-Site
10/26/2018: Hoover, Douglas

Off-Site Inspection Dates and Inspectors, if Applicable

Rec'd
11/19/18
GE

Other Details

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

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 76	**Number of Residents who:**
Number of Residents Served: 53	**Receive Supplemental Security Income:** 5
Secured Dementia Care Unit in Home: No	**Are 60 Years of Age or Older:** 51
Area:	**Have Mental Illness:** 3
Secured Dementia Unit Capacity, if Applicable:	**Have an Intellectual Disabliity:** 1
Number of Residents Served in Secured Dementia Care Unit, if applicable:	**Have a Mobility Need:** 5
Number of Current Hospice Residents: 2	**Have a Physical Disability:** 0
Number of Hospice Residents in past year: 5	

Laura Shick PCHA
11/16/18

Violation Report: 32136 - 10/26/2018 - Hoover, Douglas
PCH Name: THE PATRIOT A CHOICE COMMUNITY

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

Resident #1's daughter reported to the home on 10/1/18 that the resident told her about an early morning aide that had been "nasty and rough." In addition, she had been questioned by the local hospital on 9/26/18 regarding bruises found on Resident #1's back, as first noted by the emergency room physician on 9/22/18. Resident #1 was hospitalized from 9/22/18 to 9/26/18 and discharged to skilled nursing care in the home. Bruising was documented on the back and ribs on 9/26/18 after the hospital discharge. During a subsequent interview on 10/26/18, Resident #1 reported that Direct Care Staff Person A shook and punched him/her in the arms while providing direct care services. In addition, Resident #1 stated that Direct Care Staff Person A made him/her "feel sorry" by saying "Why can't you do this?" during incontinence care and transfers. Resident #1's support plan, dated 6/22/18, assessed the resident as having mobility needs and required the assistance of two staff for transfers, toileting and bathing needs. The home documented that Direct Care Staff Member A didn't always transfer Resident #1 with the assist of another direct care staff member and the bruising is consistent with a "bear hug" transfer. Resident #1 did not receive proper care during transfers and was subjected to physical abuse and mental anquish from Direct Care Staff Member A.

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 2A of 2. -GE

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

Signature of Legal Entity Representative (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Lori A. Fisher, PCHA

Date 11/16/18

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

The above plan of correction is approved as of 12/11/18 (Date)

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

Plan of correction implementation status as of 12/11/18 (Date)

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

THE PATRIOT

A CHOICE COMMUNITY INC.

Plan of Correction (POC): **Violation Report from Inspection on 10/26/2018 with Department Representation, Douglas Hoover:**

A thorough investigation of the allegation of abuse was conducted by Personal Care Home Administrator. PCHA could not validate or confirm that any bruising was noted or questioned from the Resident #1 Emergency room visit on 9/22/18 by the hospital, as no documentation of bruising of any kind within Resident #1 hospital records, only hearsay from Resident #1 daughter, who stated that she never saw the bruising, nor could she describe it. Bruising was noted by The Patriot's Skilled Nursing RN Supervisor upon admit on 9/26/18, however, the bruising was noted to be located on the back of Resident #1 across her bra line/rib area. Resident #1 was also taking three blood thinning medications that each have side effects which may result in bruising easily. Resident #1 during PCHA's investigation, never stated she was punched or shook in the arms and there was no bruising noted to either arm. PCHA did substantiate that Nurse Aide "A" did not follow resident's RASP and utilize a two assist for transfers and all care. According to Nurse Aide "A" statement on October 1, 2018, Nurse Aide "A" stated she was aware Resident #1 was a two-person assist. However, upon further investigation with additional facility staff, PCHA received statements from other caregivers that the Nurse Aide "A" did not always use 2 staff to transfer Resident #1 and 'bear hugged' Resident #1 for transfers. This action had the potential to cause the bruising that was noted on Resident #1 bra line area due to the transfer. Nurse Aide "A" was immediately suspended at the time of the allegation and then terminated for not using the transfer techniques outlined in Resident #1 RASP; the employee was not terminated related to the allegation, as abuse could not be substantiated. The facility was not able to substantiate the allegation of abuse based on the fact that hospital records did not validate that Resident #1 had bruising upon admission; the possibility of the bruising after Resident #1 left the personal care facility and possibly occurring at the hospital cannot be ruled out due to Resident #1 predisposition to bruising due to being prescribed and receiving 3 blood thinning medications. Resident #1 has a Dementia diagnosis and her confusion has escalated from the time the allegation was reported until the inspector arrived at our facility to investigate the allegation.

Nurse aide "A" involved in the allegation received the following training. This is not an all-inclusive list. These trainings pertain to the issue at hand and do not include training completed upon hire, just the most recent:

Abuse: 3/15/17 and 6/1/18
Resident Rights: 6/6/17 and 1/13/18
Adult Protective Services Act: 3/15/17 and 1/13/18
Elder Justice Act: 6/6/17 and 6/1/18
Stress Management: 9/13/17 and 2/3/18
Caregiver Burnout: 9/13/17 and 1/13/18
Empathy/Sympathy/Compassion: 8/8/17
Dementia Overview: 6/6/17 and 1/13/18
Dementia Behavior Management: 6/6/17 and 1/13/18
Instruction on Meeting the Need of the Resident; Preadmission Screening, DME and RASP: 7/7/17 and 6/1/18
Body Mechanics/Safe Transfers: 3/15/17 and 3/16/18

All staff received additional training on Abuse, Resident Rights, Adult Protective Services Act, Elder Justice Action and Instruction on Meeting the Need of the Resident, including RASP review on October 2, 2018.

Laura Hoover, PCHA
11/16/2018

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ThePatriotCommunity.com