pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: September 25, 2019

Mr. Anthony Kiarie
President
Evening Star, LLC
200 Caldwell Avenue
Wilmerding, Pennsylvania 15148

RE: Evening Star Personal Care Home
Certificate #: 447150

Dear Mr. Kiarie:

As a result of the Department's Bureau of Human Services Licensing inspection on September 10, 2019 and September 13, 2019, of the above facility, the citations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

Sincerely,

Jon B Kimberland

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Violation Report

Received BHSL
9/24/19

Violation Report

Facility Information

Name: *ROSECREST ASSISTED LIVING RESIDENCE*
License Number: *44445*
Address: *1000 GRAHAM WAY, P.O.BOX 1285,, MARS, PA 16046*
County: *BUTLER*
Region: *WESTERN*

Administrator

Name: *Deborah Serafine*
Phone: *(724)687-3370*
Email: *Deborah.serafine@lutheranseniorlife.org*

Legal Entity

Name: *MARS HOLDING INC*
Address: *191 SCHARBERRY LANE, MARS, PA, 16046*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff:
Total Daily Staff: *50*
Waking Staff: *38*

Inspection

Type: *Partial*
BHA Docket #:
Notice: *Unannounced*
Reason: *Incident*

Inspection Dates and Department Representative

09/10/2019 - On-Site: Scott Klein

09/13/2019 - Off-Site: Scott Klein

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *30*
Residents Served: *25*

Special Care Unit

In Home: *Yes*
Area: *Entire Home*
Capacity: *30*
Residents Served: *25*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *25*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *25*
Have Physical Disability: *0*

15a Resident abuse report

Requirements

2800.

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

Description of Violation

On 8/26/19 at approximately 6:55 p.m., direct care staff person A removed resident #1's clothing against the wishes of the resident by pulling a button-down shirt off over the resident's head in a rough manner while buttons were still fastened at the wrist cuffs and 2 buttons below the neckline, and then forcibly took the television remote from the resident's hands. This incident was reported to staff person B on 8/26/19 at approximately 10:00 p.m. However, this allegation of abuse was not reported to the local Area Agency on Aging until 8/27/19 at approximately 4:30 p.m.

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

See Pages 2A and 2B of 3

Legal Entity Representative

Signature

Deborah Serafini, ALA 9/26/19

Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/25/19 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 9/25/19 (Date)

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

RoseCrest Assisted Living

Plan of Correction

Inspection Date – 9/10/2019

Licensing Violation

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

On 8/26/19 at approximately 6:55 p.m., direct care staff person A removed resident #1's clothing against the wishes of the resident by pulling a button-down shirt off over the resident's head in a rough manner while buttons were still fastened at the wrist cuffs and 2 buttons below the neckline, and then forcibly took the television remote from the resident's hands. This incident was reported to staff person B on 8/26/19 at approximately 10:00 p.m. However, this allegation of abuse was not reported to the local Area Agency on Aging until 8/27/19 at approximately 4:30 p.m.

Why did it happen?

Staff Person B felt that since she had not witnessed the incident that she did not need to report it to anyone even though Resident #1 had told her what had happened.

What do we do right now to fix the problem?

Who – Staff person A was immediately removed from the facility and has been DNR'd from our facility. The administrator contacted the staffing agency and told them of what happened and the next day sent an email to the staffing agency stating that Staff Person A is not to come back here anymore.

What – The administrator will continue to ensure that this person does not work in the facility. Staff education was provided to all staff by the administrator to ensure that everyone is aware of their responsibilities to report suspected neglect or abuse. Education was provided by the Administrator to the Health Care Coordinators on how to report suspected abuse, who to report to, timelines of when reports are to be made, and how to complete the appropriate reports.

When – Staff person A was immediately removed from the facility upon the incident being reported to the Administrator. Training was conducted with the staff shortly after the incident occurred at the staff meeting on September 6th. Training with the Health Care Coordinators was conducted on 9/19/2019.

9/24/19 9/25/19

How do we prevent this from happening again?

Who – The administrator will continue to provide education on OAPSA and reporting guidelines for abuse and neglect. All agency staff that comes into the facility will be trained on what abuse is and how to report it.

What – There is an Agency Orientation Training binder that all agency staff is to review prior to beginning to work in the facility. Administrator will continue to ensure that this is being done. Facility staff will receive training annually according to the training plan. One on one education will be done with Staff member B to ensure that they understand the expectations for reporting any suspected abuse or neglect.

When – There has always been agency training, however, the agency orientation training was just updated a few months ago and is complete with our abuse policies, information on OAPSA, and reporting guidelines. This training will be given annually to all agency employees working here. Our facility staff also receives this training annually. Staff member B was given one on one education by the administrator ensuring that they are aware of their responsibilities for reporting suspected abuse or neglect.

Timeline/Work Plan

Action	Owner	Completion Date
Staff Person A Suspended	Administrator	8/27/2019
Staff Person A DNR'd	Administrator	8/28/2019
All staff educated on reporting guidelines	Administrator	9/6/2019
Training with Health Care Coordinators on reporting procedures	Administrator	9/19/2019
One on One education with Staff Person B	Administrator	9/20/2019

Immediately: The administrator shall audit all allegations of abuse to ensure that the reporting requirements of the Older Adult Protective Services Act and regulation 2600.15(c) are met. 9/25/19

9/24/19

9/25/19

42c Dignity/Respect

Requirements

2800.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 8/26/19 at approximately 6:55 p.m., direct care staff person A removed resident #1's clothing against the wishes of the resident by pulling a button-down shirt off over the resident's head in a rough manner while buttons were still fastened at the wrist cuffs and 2 buttons below the neckline, and then forcibly took the television remote from the resident's hands. Resident #1 states the incident made him feel upset and afraid that if reported, he may be forced to leave the home.

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

See Pages 3A and 3B of 3

Legal Entity Representative

Signature

Deborah Serafin, ALA 9/24/19

Printed Name and Title Date

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

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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

RoseCrest Assisted Living

Plan of Correction

Inspection Date – 9/10/2019

Licensing Violation

2800.42.c. A resident shall be treated with dignity and respect.

On 8/26/19 at approximately 6:55 p.m., direct care staff person A removed resident #1's clothing against the wishes of the resident by pulling a button-down shirt off over the resident's head in a rough manner while buttons were still fastened at the wrist cuffs and 2 buttons below the neckline, and then forcibly took the television remote from the resident's hands. Resident #1 states the incident made him feel upset and afraid that if reported, he may be forced to leave the home.

Why did it happen?

Staff Person A became inpatient with Resident #1 and this resulted in the resident feeling upset and afraid.

What do we do right now to fix the problem?

Who – The administrator immediately talked to Resident #1 and assured him that there would be no retaliation against him for reporting this incident. The administrator apologized to him that this incident took place and assured him that the agency employee would not be back to work here anymore.

What – Staff person A was immediately removed from the facility and DNR'd from working at the facility.

When – The incident was reported to the administrator at 2:15pm. Staff Person A was to begin working at 3pm. The administrator called the agency employee into her office, had her write a statement, and then sent her home on suspension. The administrator called the staffing agency and informed them of what had happened. The next morning the administrator emailed the staffing agency informing them that this agency employee was not to return to the facility anymore.

How do we prevent this from happening again?

Who – the administrator provided education on what abuse is, how to report it, and ways to relieve stress. Also talked about ways for employees to be mindful of their health so that they don't get burnt out and frustrated.

9/24/19 9/25/19

What – The administrator will continue to provide annual trainings to the staff on dignity and respect as well as OAPSA and abuse reporting. Agency staff have an orientation training that they are to complete before working in the facility. This outlines the abuse policies, OAPSA, and abuse reporting.

When – Staff is trained annually according to our training plan. Agency staff is trained when they begin working here and will be trained annually also.

Timeline/Work Plan

Action	Owner	Completion Date
Staff Person A Suspended	Administrator	8/27/2019
Staff Person A DNR'd	Administrator	8/28/2019
All staff educated on reporting guidelines	Administrator	9/6/2019

By 10/15/19: The administrator shall privately interview at least two residents a week for three months concerning being treated with dignity and respect. Documentation of interviews shall be kept. 9/25/19

9/24/19

9/25/19