

Department of Human Services
Bureau of Human Service Licensing

September 2, 2020

DANIEL GUILL, PRESIDENT/CEO
LOWRIE AID OPCO LLC
330 NORTH WABASH, SUITE 3700
CHICAGO, IL 60611

RE: LOWRIE PLACE
100 STERLING VILLAGE DRIVE
BUTLER, PA, 16001
LICENSE/COC#: 44496

Dear Mr. Guill,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 07/09/2020 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY**

Facility Information

Name: *LOWRIE PLACE* License #: *44496* License Expiration Date: *04/18/2021*
 Address: *100 STERLING VILLAGE DRIVE, BUTLER, PA 16001*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: *Cindy Naughton* Phone: *7242872171* Email:
ALCLICENSE@ENLIVANT.COM; suzquinn@pa.gov

Legal Entity

Name: *LOWRIE AID OPCO LLC*
 Address: *330 NORTH WABASH, SUITE 3700, CHICAGO, IL, 60611*
 Phone: *7242872171* Email: *LEGALHELP@ENLIVANT.COM*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/07/1997* Issued By: *L & I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *42* Waking Staff: *32*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *07/14/2020*

Inspection Dates and Department Representative

07/09/2020 - On-Site: Lori Gillette

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *47* Residents Served: *38*

Secured Dementia Care Unit

In Home: <i>No</i>	Area:	Capacity:	Residents Served:
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Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>38</i>
Diagnosed with Mental Illness: <i>5</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>4</i>	Have Physical Disability: <i>1</i>

Inspections / Reviews

07/09/2020 - Partial

Lead Inspector: *Lori Gillette*Follow-Up Type: *POC Submission*Follow-Up Date: *08/31/2020*

9/2/2020 - POC Submission

Lead Reviewer: *Suzy Quinn*Follow-Up Type: *Document Submission*Follow-Up Date: *09/30/2020*

15a - Resident Abuse Report

1. Requirements

2600.

- 15.a. The home 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 6/6/2020, at 4:30 pm, staff person A followed resident #1 outside the home and attempted to re-direct him back inside because he was confused. Resident #1 refused to come back inside and became agitated with staff. Resident #1 lifted his cane to staff person A and this staff grabbed onto the resident's cane. Staff person A and resident #1 briefly pulled back and forth at the cane. Staff person A turned her position while resident #1 continued to hold onto the cane which caused the resident to fall. This incident was observed by staff persons B and C. However, this allegation of abuse was not reported to the Area Agency on Aging until 6/10/2020.

Plan of Correction

Accept

Plan of Correction

Regulation 2600.15.a

- 1. Staff member B and C were educated by the ED on the reporting requirements for suspected abuse allegations and in accordance with the Older Adult Protective Service Act on 06/12/2020 and Regulation 2600.15.a to ensure the timely reporting of suspected resident abuse to the Area Agency on Aging. Staff member C is no longer an active employee as of 07/31/2020.*
- 2. Employees will be educated by 08/31/2020 by the Ed or designee to contact the supervisor immediately of any allegations of abuse 24 hours a day 7 days a week and the reporting requirements for suspected abuse allegations and in accordance with the Older Adult Protective Service Act and Regulation 2600.15.a.*
- 3. Resident Council attendees will be educated by September 30, 2020 by LEC or designee on abusive type behaviors and reporting those type behaviors immediately.*
- 4. Incident reports will be reviewed at the monthly QI meetings to determine any ongoing concerns regarding timely reporting.*

Plan of Correction

Disclaimer Statement

Submission of this response and Plan of correction is NOT a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cite, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Corrections. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Completion Date: 08/31/2020

15b - Supervisor Plan

1. Requirements

2600.

15b - Supervisor Plan (continued)

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.

Description of Violation

On 6/6/2020, at 4:30 pm, staff person A followed resident #1 outside the home and attempted to re-direct him back inside because he was confused. Resident #1 refused to come back inside and became agitated with staff. Resident #1 lifted his cane to staff person A and this staff grabbed onto the resident's cane. Staff person A and resident #1 briefly pulled back and forth at the cane. Staff person A turned her position while resident #1 continued to hold onto the cane which caused the resident to fall. This incident was observed by staff persons B and C. However, the home did not develop a plan of supervision or suspend staff person A until 6/10/2020 and she continued to work unsupervised on 6/7/2020 and 6/9/2020.

Plan of Correction**Accept**

Plan of Correction

Regulation 2600.15.b

- 1. The incident regarding resident #1 occurred on 6/6/2020 and was reported to the Department on 6/10/2020. Staff member A was put on suspension on 6/10/2020 pending an investigation.*
- 2. There were no other reported instances of alleged or suspected abused in the community requiring suspension of staff.*
- 3. CSM and CRM will be educated by 9/8/2020 by the ED on the need to immediately develop and implement a plan of supervision of the involved staff person pending an investigation according to Regulation 2600.15.b.*
- 4. Incident reports will be reviewed at the monthly QI meetings to determine ongoing concerns regarding immediate plan of supervision or employee suspension.*

Plan of Correction

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Completion Date: 08/31/2020

15c - Supervision**1. Requirements**

2600.

- 15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

15c - Supervision (continued)

Description of Violation

On 6/6/2020, at 4:30 pm, staff person A followed resident #1 outside the home and attempted to re-direct him back inside the because he was confused. Resident #1 refused to come back inside and became agitated with staff. Resident #1 lifted his cane to staff person A and this staff grabbed onto the resident's cane. Staff person A and resident #1 briefly pulled back and forth at the cane. Staff person A turned her position while resident #1 continued to hold onto the cane which caused the resident to fall. This incident was observed by staff persons B and C. However, the home did not submit to the Department a plan of supervision or notice of suspension for staff person A until 6/10/2020 and she continued to work unsupervised on 6/7/2020 and 6/9/2020.

Plan of Correction**Accept***Plan of Correction**Regulation 2600.15.c*

1. The incident regarding resident #1 occurred on 6/6/2020 and was reported to the Department on 6/10/2020 by the ED. Staff member A was put on suspension on 6/10/2020 pending an investigation.
2. There were no other instances of alleged or suspected abused in the community requiring reporting to the Department.
3. CSM and CRM will be educated by 9/8/2020 on the need to immediately develop and implement a plan of supervision of the involved staff person pending an investigation and submit the plan to the Department according to Regulation 2600.15.c.
4. Incident reports will be reviewed at the monthly QI meetings to determine ongoing concerns regarding immediate plan of supervision or employee suspension.

*Plan of Correction**Disclaimer Statement*

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Completion Date: 08/31/2020

16c - Written Incident Report

1. Requirements

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 § 2600.15 (relating to abuse reporting covered by law).

16c - Written Incident Report *(continued)***Description of Violation**

On 6/6/2020, at 4:30 pm, staff person A followed resident #1 outside the home and attempted to re-direct him back inside because he was confused. Resident #1 refused to come back inside and became agitated with staff. Resident #1 lifted his cane to staff person A and this staff grabbed onto the resident's cane. Staff person A and resident #1 briefly pulled back and forth at the cane. Staff person A turned her position while resident #1 continued to hold onto the cane which caused the resident to fall. This incident was observed by staff persons B and C. However, this allegation of abuse was not reported to the Department until 6/10/2020.

Plan of Correction**Accept***Plan of Correction**Regulation 2600.16.c*

1. Staff member B and C were educated on the reporting requirements for suspected abuse allegations and in accordance with the Older Adult Protective Service Act on 06/12/2020 and Regulation 2600.15.a to ensure the timely reporting of suspected resident abuse to the Department Personal Care Home Regional Office within 24 hours. Staff member C is no longer an active employee as of 07/31/2020.
2. Employees will be educated by 08/31/2020 to contact the supervisor immediately of any allegations of abuse 24 hours a day 7 days a week and the reporting requirements for suspected abuse allegations and in accordance with the Older Adult Protective Service Act and Regulation 2600.16.a.
3. Resident Council attendees will be educated by September 30, 2020 on abusive type behaviors and reporting those type behaviors immediately.
4. Incident reports will be reviewed at the monthly QI meetings to determine any ongoing concerns regarding timely reporting.

*Plan of Correction**Disclaimer Statement*

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Completion Date: 08/31/2020

228b - Discharge or Transfer

1. Requirements

2600.

- 228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

228b - Discharge or Transfer (continued)

Description of Violation

On 6/24/2020, the home notified the resident's designated person and the hospital that resident #1 would be unable to return to the home due to agitation and aggression with violent behaviors and the home was unable to care for him safely as he was a threat to the safety of the staff and other residents. However, the home did not provide a 30 day advance written notification of discharge to the resident, the resident's designated person and the referral agent citing the reasons for the discharge. The home did not obtain certification from a physician or the Department that a delay in discharge would jeopardize the health, safety or well-being of the resident or others in the home.

Plan of Correction**Accept***Plan of Correction**Regulation 2600.228.b*

- 1. Resident #1 discharged on June 9, 2020 from the community to the hospital and was admitted to a secured memory care unit upon discharge from the hospital.*
- 2. There are no known resident discharges from the community due to safety within the past year. Residents will be issued a 30 days written advanced notice of discharge should the home be unable to meet the needs or secure the safety of a resident. The home will secure physician documentation for any situation that would jeopardize the health, safety, or well-being of the resident or others in the home.*
- 3. CSM will be educated by 09/7/2020 by the ED on Regulation 2600.228.b and the requirements to issue a 30 advance written notice of a resident discharge or obtain physician documentation.*
- 4. Community initiated resident discharges will be reviewed at the monthly QI meeting to ensure a 30 day advanced written notice was provided or physician's documentation was obtained.*

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Completion Date: 08/31/2020