

Department of Human Services
Bureau of Human Service Licensing

May 4, 2022

[REDACTED]
ST. ANNE HOME INC
685 ANGELA DRIVE
GREENSBURG, PA, 15601

RE: VILLA ANGELA AT ST. ANNE HOME
685 ANGELA DRIVE
GREENSBURG, PA, 15601
LICENSE/COC#: 42804

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/18/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Janine Wenzig

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

May 2, 2022

[REDACTED]
ST. ANNE HOME INC
685 ANGELA DRIVE
GREENSBURG, PA, 15601

RE: VILLA ANGELA AT ST. ANNE HOME
685 ANGELA DRIVE
GREENSBURG, PA, 15601
LICENSE/COC#: 42804

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 03/18/2022 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,
Janine Wenzig

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *VILLA ANGELA AT ST. ANNE HOME* License #: *42804* License Expiration: *02/05/2023*
Address: *685 ANGELA DRIVE, GREENSBURG, PA 15601*
County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: *7248376070 x 3054* Email: [REDACTED]

Legal Entity

Name: *ST. ANNE HOME INC*
Address: *685 ANGELA DRIVE, GREENSBURG, PA, 15601*
Phone: *7248376070* Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *03/18/2022* Issued By: *Labor @ Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *36* Waking Staff: *27*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Complaint, Incident* Exit Conference Date: *03/18/2022*

Inspection Dates and Department Representative

03/18/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *54* Residents Served: *34*

Secured Dementia Care Unit

In Home: *No* Area: Capacity: Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *34*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *2* Have Physical Disability: *0*

Inspections / Reviews

03/18/2022 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/28/2022*

04/29/2022 - POC Submission

Inspections / Reviews *(continued)*

Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/02/2022*

05/02/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *05/04/2022*

05/04/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.

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

Description of Violation

On 3/15/22, at approximately 7:05 a.m., resident #1, told staff person A that [REDACTED] left toe was sore, and requested the use of an assistive device. Staff person A, said no, and put a shoe on resident #1's foot anyway, causing the resident to cry out in pain. Approximately 5 minutes later, when resident #1 was on the toilet, staff person A folded a wet wash cloth and pushed it into resident #1's mouth, while repeatedly and loudly said the resident's name, causing the resident to feel fear, shock and disbelief that anyone could do such a terrible thing.

Approximately 1 hour later, resident #1, pressed [REDACTED] r call bell for assistance. Staff person A responded and said "What do you want now?" Resident #1 replied that the staff person did not clean [REDACTED] sufficiently after toileting, and [REDACTED] could still smell feces on [REDACTED] brief. Resident #1 propelled [REDACTED] to the elevator to get assistance from someone else. Staff person A pulled resident's wheelchair back, preventing the resident from getting into the elevator and stated, "You don't have any friends and no one likes you."

On multiple occasions, staff person A loudly and repeatedly said resident 1's full name aloud, deliberately ignoring the resident's request not to do so, particularly in public spaces. The resident prefers to have privacy.

Plan of Correction**Accept**

1. On March 15, 2022, at 10:23am Director of Villa Angela suspended staff member A without pay pending the outcome of the investigation as per facility policy. Upon completion of investigation facility found allegation to be substantiated and staff member A's employment was terminated by the Director of Villa Angela on March 22, 2022.

2. Education will be provided by Director of Villa Angela to Villa Angela staff members on the following:

- Policy # CC. 0008 Protection against Resident Abuse, Neglect, and Misappropriation of Resident Property
- 2600.42 Specific Rights
- 2600.43 Prohibition against deprivation of rights
- 2600.44 Complaint procedures
- Suspected resident abuse reporting and Investigation requirements

Staff will sign that they have received, read, and understand the above education.

Education will be provided to staff by 04/25/22

3. The administrator or designee will interview 6 residents regarding care and treatment monthly for the next 6 months, then twice a year moving forward to ensure compliance with §2600.42(b). First monthly interviews will take place on 04/29/22.

42b - Abuse (continued)

The administrator or designee will increase supervision of staff during care to ensure that staff are proficiently assisting residents with personal care needs in a manner that is compliant with §2600.42(b).

4. Completion date: 04/29/22

Completion Date: 04/29/2022

Document Submission**Implemented**

Directed -

Within 60 calendar days of receipt of the plan of correction: The home will conduct a quality management plan review and evaluation. The Administrator will place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights and Older Adult Protective Services Act (OAPSA) training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and §2600.65(b)(3) and annually in accordance with §2600.65(g)(3) and §2600.65(g)(4).