

Department of Human Services
Bureau of Human Service Licensing

May 23, 2022

[REDACTED]
MAYBROOK-C EVERGREEN OPCO LLC
[REDACTED]

RE: THE GROVE AT HARMONY
191 EVERGREEN MILL ROAD
HARMONY, PA, 16037
LICENSE/COC#: 44757

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/19/2022, 04/20/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: *THE GROVE AT HARMONY* License #: *44757* License Expiration: *02/15/2023*
Address: *191 EVERGREEN MILL ROAD, HARMONY, PA 16037*
County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *MAYBROOK-C EVERGREEN OPCO LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *11/16/1988* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *4* Waking Staff: *3*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *04/26/2022*

Inspection Dates and Department Representative

[REDACTED] /2022 - On-Site: [REDACTED]
[REDACTED] /2022 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *44* Residents Served: *4*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* Are 60 Years of Age or Older: *4*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

04/19/2022 - Partial

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

Inspections / Reviews (*continued*)

█/2022 - POC Submission

Reviewer: █

Follow-Up Type: *Document Submission* Follow-Up Date: █/2022

█/2022 - Document Submission

Reviewer: █

Follow-Up Type: *Not Required*

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 [REDACTED]/22, [REDACTED] resident #1, who requires assistance of two persons with transferring for safety, was heard moaning and yelling for help from the bedroom. Staff persons A, B and a visiting nursing home staff person went to the resident's bedroom and found the resident standing by the dresser, trying to hold him/herself up from falling as the resident's right leg was twisted. Staff person A assisted the resident in standing as staff person B went to get a wheelchair. The resident was asked what happened and the resident indicated he/she couldn't stand. Staff persons A and B assist the resident into a wheelchair that did not have leg rests. As the resident was sitting in the wheelchair, staff person A asked the resident if he/she was able to lift and straighten their leg to help assist in moving the wheelchair. The resident indicated the inability to move the right leg. Staff person A then in a demanding voice, yelled at the resident "get into that bed and help yourself". The resident responded in a scared manner, "I can't". Staff person A then asked the resident if he/she was ready to go to bed, the resident said "no". Staff person A grabbed the resident's knees and pulled the resident in the wheelchair toward the bed. The resident begged staff person A to stop, saying "you're hurting me". Staff person A stated, "you're going to bed". Staff person A grabbed the resident under the arms in a bear hug and quickly transferred the resident onto the bed as the resident begged staff person to stop. The resident landed on their left side on the bed with their legs hanging off the side of the bed. Resident #1 again indicated to staff person A "you're hurting me". Staff person A picked up the resident's legs and dropped them onto the bed and then grabbed the resident's right arm and pulled the resident down to a laying flat position as the resident kept begging to stop and stating, "you're hurting me".

This allegation of abuse was not reported in accordance with the Older Adult Protective Services Act until [REDACTED]

Plan of Correction

Accept

Immediate: Staff Person B failed to report abuse until the end of [REDACTED] overnight shift. Administrator contacted employee and explained any allegation of abuse must be reported at the time the incident occurs. It does not matter what time of the day/night; It must be reported immediately.

Education: All current staff were re-trained on reporting abuse/Neglect with an emphasis on timely reporting and the importance of making sure resident is safe.

ongoing: Annual education on Abuse/Neglect is required for all staff.

Completion Date: [REDACTED] 2022

Document Submission

Implemented

retraining of staff documentation

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.

42b - Abuse (continued)**Description of Violation**

On [REDACTED]/22, [REDACTED], resident #1, who requires assistance of two persons with transferring for safety, was heard moaning and yelling for help from the bedroom. Staff persons A, B and a visiting nursing home staff person went to the resident's bedroom and found the resident standing by the dresser, trying to hold him/herself up from falling as the resident's right leg was twisted. Staff person A assisted the resident in standing as staff person B went to get a wheelchair. The resident was asked what happened and the resident indicated he/she couldn't stand. Staff persons A and B assist the resident into a wheelchair that did not have leg rests. As the resident was sitting in the wheelchair, staff person A asked the resident if he/she was able to lift and straighten their leg to help assist in moving the wheelchair. The resident indicated the inability to move the right leg. Staff person A then in a demanding voice, yelled at the resident "get into that bed and help yourself". The resident responded in a scared manner, "I can't". Staff person A then asked the resident if he/she was ready to go to bed, the resident said "no". Staff person A grabbed the resident's knees and pulled the resident in the wheelchair toward the bed. The resident begged staff person A to stop, saying "you're hurting me". Staff person A stated, "you're going to bed". Staff person A grabbed the resident under the arms in a bear hug and quickly transferred the resident onto the bed as the resident begged staff person to stop. The resident landed on their left side on the bed with their legs hanging off the side of the bed. Resident #1 again indicated to staff person A "you're hurting me". Staff person A picked up the resident's legs and dropped them onto the bed and then grabbed the resident's right arm and pulled the resident down to a laying flat position as the resident kept begging to stop and stating, "you're hurting me".

Plan of Correction**Accept**

Immediate: Staff person A was suspended and had no further contact with the resident. Subsequently, investigation found just cause for Staff person A to be terminated from employment.

Education:

All current staff were re-trained on reporting abuse/Neglect with an emphasis on timely reporting and the importance of making sure resident is safe.

Ongoing: Annual education on Abuse/Neglect is required for all staff. This is currently a self study program provided by OAPS. ? Facility has also applied for an account for the online power point education by OAPS

AMMENDED PLAN:

The administrator or designee shall privately interview at least 4 residents per month for 3 months to discuss how they are treated in the home and if they have any concerns with their interactions with the home's staff.

Documentation of these discussions shall be kept. JW 5/13/22

Completion Date: [REDACTED]/2022

Document Submission**Implemented**

4 residents were interviewed on [REDACTED] 2022 by administrator. Subsequent interviews shall take place on [REDACTED]/2022

42b - Abuse (continued)

and [REDACTED]/2022.