

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

March 23, 2023

[REDACTED]  
GREER AID OPCO LLC  
[REDACTED]  
[REDACTED]

RE: CLEN-MOORE PLACE  
22 WEST CLEN MOORE BOULEVARD  
NEW CASTLE, PA, 16105  
LICENSE/COC#: 44493

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/21/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,  
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: *CLEN-MOORE PLACE* License #: *44493* License Expiration: *07/11/2023*  
 Address: *22 WEST CLEN MOORE BOULEVARD, NEW CASTLE, PA 16105*  
 County: *LAWRENCE* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *GREER AID OPCO LLC*  
 Address: *330 N WABASH AVE SUITE 3700, CHICAGO, IL, 60611*  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: *03/05/1997* Issued By: *L&I*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *48* Waking Staff: *36*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
 Reason: *Incident* Exit Conference Date: *11/21/2022*

**Inspection Dates and Department Representative**

11/21/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: *47* Residents Served: *31*

**Secured Dementia Care Unit**  
 In Home: *No* Area: Capacity: Residents Served:

**Hospice**  
 Current Residents: *4*

**Number of Residents Who:**  
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *31*  
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *17* Have Physical Disability: *0*

**Inspections / Reviews**

11/21/2022 - Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/26/2022*

01/12/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: *02/02/2023*  
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/19/2023*

Inspections / Reviews *(continued)*

03/23/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/02/2023

Reviewer: [REDACTED]

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

Staff indicated on [REDACTED], at approximately [REDACTED], while at the dining room table, staff person A was observed face-to-face with resident #1, yelling at each other. At approximately [REDACTED] staff person A was observed yelling at resident #1 in a loud, demeaning, and frustrated tone of voice, telling resident #1 "that's not right, you shouldn't be doing that", as resident #1 was attempting to kick staff person A. At approximately [REDACTED] staff person A was observed asking resident #3 in a loud and irritated tone of voice "what are you talking about" as resident #3 was mumbling in confusion. However, these allegations of suspected abuse were not reported to the local Area Agency on Aging until [REDACTED].

Plan of Correction

Accept (JW - 01/12/2023)

- Resident #1 and resident #3 were assessed on [REDACTED] by Care Service Manager (CSM) with no abnormal findings. Allegation was reported to local Area Agency on Aging on [REDACTED] by the Executive Director (ED).
- On [REDACTED], staff person A was placed on administrative leave pending the outcome of the investigation. Staff person A remains on leave at this time per DHS recommendation.
- On 11/8/2022, ED and CSM interviewed other residents and staff to ensure no other incidents occurred which had not been reported. No other incidents were identified.
- On 11/8/2022, ED and CSM audited 24 hour report and concern log for past 90 days to ensure allegation reported to local Area Agency on Aging timely. No allegations were noted which had not been reported to the local Area Agency on Aging.
- On 11/25/2022, ED provided in-service to staff on mandated reporting, Older Adults Protective Services Act (OAPSA) and requirements set within regulation 2600.15a. (Exhibit 1.A – In-service)
- Starting 1/2/2023, ED or designee will interview 1 resident and 1 staff member weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure there are no incidents of suspected abuse of a resident served in the home which have not been reported. (Exhibit 1.B – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 03/27/2023

Licensee's Proposed Overall Completion Date: 03/27/2023

Implemented (JG - 03/23/2023)

16c - Written Incident Report

2. 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

Staff indicated on [redacted] at approximately [redacted], while at the dining room table, staff person A was observed face-to-face with resident #1, yelling at each other. At approximately [redacted], staff person A was observed yelling at resident #1 in a loud, demeaning, and frustrated tone of voice, telling resident #1 "that's not right, you shouldn't be doing that", as resident #1 was attempting to kick staff person A. At approximately [redacted], staff person A was observed asking resident #3 in a loud and irritated tone of voice "what are you talking about" as resident #3 was mumbling in confusion. However, these incidents were not reported to the home until [redacted] at approximately 3:00 pm. The home did not report these incidents to the Department until [redacted]

Plan of Correction

Accept (JW - 01/12/2023)

- Resident #1 and resident #3 were assessed on [redacted] by Care Service Manager (CSM) with no abnormal findings. Allegation was reported to Department of Human Services on [redacted] by the Executive Director (ED).
- On [redacted], staff person A was placed on administrative leave pending the outcome of the investigation. Staff person A remains on leave at this time per DHS recommendation.
- On 11/8/2022, ED and CSM interviewed other residents and staff to ensure no other incidents occurred which had not been reported. No other incidents were identified.
- On 11/8/2022, ED and CSM audited 24 hour report and concern log for past 90 days to ensure allegation reported to DHS timely.
- On 11/25/2022, ED provided in-service to staff on mandated reporting, Older Adults Protective Services Act (OAPSA) and requirements set within regulation 2600.16c. (Exhibit 2.A – In-service)
- Starting 1/2/2023, ED or designee will interview 1 resident and 1 staff member weekly x 4 weeks, bi-weekly x 4 weeks and monthly x 1 month to ensure there are no incidents of suspected abuse of a resident served in the home which have not been reported. (Exhibit 2.B – Audit Tool)
- ED will discuss the results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 03/27/2023

Licensee's Proposed Overall Completion Date: 03/27/2023

Implemented (JG - 03/23/2023)

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person B, whose first day of work was [redacted], did not receive any of the required first day orientation.

Plan of Correction

Accept (JW - 01/12/2023)

- On [redacted] staff person B was removed from the schedule. [redacted] was an agency employee and his contract ended and was not renewed.
- On 11/21/2022, ED reviewed current staffing records to ensure first day orientation was provided per regulatory

**65a - FS Orientation 1st Day (continued)**

requirements. No other issues were identified.

- On 12/1/2022, Regional Director of Care Services (RDCS) re-educated ED and CSM on the requirements set within regulation 2600.65.a. (Exhibit 3.A – In-service)
- Starting 1/2/2023, ED or designee will review 2 new hire employee records weekly x 4 weeks, bi-weekly x 4 weeks, monthly x 1 month to ensure continued compliance with regulation 2600.65a. (Exhibit 3.B – Audit Tool)
- ED will discuss results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 03/27/2023

Licensee's Proposed Overall Completion Date: 03/27/2023

**Implemented (JG - 03/23/2023)**

**225c - Additional Assessment**

**4. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.

**Description of Violation**

Resident #2's assessment, dated [REDACTED], does not include the resident's need for assistance in transferring and ambulation and issue with irritability, agitation, aggression, and ability to communicate needs.

Resident #3's assessment, dated [REDACTED], does not include the resident's need for assistance in toileting, ability to communicate needs, and understand instructions.

**Plan of Correction**

**Accept (JW - 01/12/2023)**

- On [REDACTED], CSM reviewed and updated resident #2's assessment and support plan (RASP) to reflect current needs as well as the plan to meet those needs.
- On [REDACTED], CSM reviewed and updated resident #3's assessment and support plan (RASP) to reflect current needs as well as the plan to meet those needs.
- On 11/25/2022, CSM conducted audit of current residents' RASPs to ensure a description of service needs and plan to meet those needs were included. Any required updates were made at time of finding.
- On 11/25/2022, ED in-serviced the CSM on requirements set within regulation 2600.225c (Exhibit 4.A– Inservice)
- Starting 1/2/2023, ED and/or designee will audit 2 residents' RASPs weekly x 4 weeks, biweekly x 4 weeks, monthly x 1 month to ensure they reflect residents' current needs and plan to meet those needs to remain in compliance with regulation 2600.225c. (Exhibit 4.B – Audit tool)
- ED will discuss results of the audit during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance.
- Completion Date: 03/27/2023

Licensee's Proposed Overall Completion Date: 03/27/2023

**Implemented (JG - 03/23/2023)**