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

March 13, 2023

[redacted]
CRANBERRY PLACE
1201 CUMBERLAND ROAD
[redacted]
PITTSBURGH, PA, 15237

RE: CUMBERLAND CROSSING MANOR
1201 CUMBERLAND ROAD
PITTSBURGH, PA, 15237
LICENSE/COC#: 44616

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/26/2023, 01/27/2023, 01/30/2023 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: *CUMBERLAND CROSSING MANOR* **License #**: *44616* **License Expiration**: *06/30/2023*

Address: *1201 CUMBERLAND ROAD, PITTSBURGH, PA 15237*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CRANBERRY PLACE*

Address: *1201 CUMBERLAND ROAD, ATTN: ROGER DAVIS,COO, PITTSBURGH, PA, 15237*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP*	**Date**: *10/09/1998*	**Issued By**: *L & I*
Type: *I-1*	**Date**: *06/06/2018*	**Issued By**: *Twp of McCandles*
Type: *I-1*	**Date**: *02/02/1998*	**Issued By**: *Twp of McCandles*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *118* **Waking Staff**: *89*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *01/30/2023*

Inspection Dates and Department Representative

01/26/2023 - On-Site: [redacted]
01/27/2023 - Off-Site: [redacted]
01/30/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *78*

Special 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**: *78*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *40* **Have Physical Disability**: *0*

Inspections / Reviews

01/26/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/17/2023*

02/21/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/09/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/28/2023*

03/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/09/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/09/2023*

03/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/09/2023*

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

15a Resident abuse report

1. 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 [redacted] between [redacted]., staff person A, was assisting resident #1 with a shower. Resident #1 reported staff person A sprayed cold water in the resident's face and across their torso, while laughing and saying, "Isn't this fun, we are having fun.". Resident #1 reported telling staff person A, "no, I am not having fun, I don't like that." Resident #1's tip of nose began to bleed, staff person A requested staff person B's assistance.

Staff person B entered resident #1's room and heard resident#1 telling staff person A, to "stop it, stop it." Staff person B while tending to the resident's nose inquired how it happened, and if was the resident, who appeared upset was, ok? Resident #1 abruptly stated, "NO, NO, I am not ok, my nose is bleeding because [redacted] sprayed me in the face with cold water. Staff person A was observed laughing about the incident. Staff person B, responded with, "we don't spray people in the face with water, it is not ok." Staff person B left the room and staff person provided care to resident #1, as well as other residents in the home.

Staff person B reported returning to resident #1's room between approximately 8:00 or 8:30 p.m. and found resident #1 still upset telling staff person C, about the incident. Resident #1 stated, I am upset. I told staff person A to stop, that I don't like that, but she just doesn't stop.

This abuse was not reported to the Local Area Agency on Aging.

Plan of Correction ***Accept (JK - 03/02/2023)***

Allegations of abuse are to be reported immediately to Area Agency on Aging(Protective Services) then to DHS Western Region office for investigation. The reporting process begins with notification, triggering response by Protective Services and Regional Licensing to investigate. The internal investigation does not need to substantiate the allegation, rather inviting a more thorough investigation to ensue. As demonstrated in this scenario, a more thorough investigation provided details not shared by resident to any staff member at CCM. Staff person B did report to chain of command, charge nurse did report complaint to leadership. Administrator or designee should have suspended staff person A immediately pending investigation of abuse. For protection of staff member and resident's, immediate suspension of staff member to investigate allegations if preferrable to plan of supervision. Initial complaint interview with resident was deemed poor judgement by caregiver and unlikely abuse. Resident did not share whole story for fear of retaliation. Resident was interviewed by Protective services [redacted] as complaint investigation with no substantiation of abuse, not all details were disclosed by resident during interview. Details of pattern were disclosed by resident to BHSL representative 1/30/23 and shared with Administrator and Director of Resident Care during interview 1/31/23.

Administrator currently investigates resident's written complaints. Administrator, or designee, will audit complaint(s) to ensure compliance with 2800,15.a., Resident abuse reporting in accordance with Older Adult Protective Services Act and PA Code(relating to reporting suspected abuse) and comply with requirements regarding restrictions on staff persons. Audit of complaints will allow for home to report any allegations of abuse or neglect to AAA and Department. Audit of complaints will continue weekly for 14 weeks to ensure compliance. Audits will be reviewed during Quality Management meeting. There have been no allegations of abuse or neglect since audit period began 2/22/23.

15a Resident abuse report (continued)

Administrator participated in education opportunity 2/8/23, Conducting a Thorough Investigation. See attached. Staff education was provided 1/27/23(Abuse: Preventing, Identifying and reporting) and 2/16/23(Abuse Reporting, Mandatory Reporter). Staff members B and C received education. See attached. Resident Right's education to be provided by Ombudsman at employee in-service by 3/31/23. Abuse Reporting and Mandatory Reporter education training to be provided by Protective Services at employee in-service by 3/31/23. Record of attendance and content will be recorded and submitted to Department.

Resident #1 scheduled discharged from CCM [redacted].
Staff Person A is no longer employed by residence, last day worked was [redacted].

Licensee's Proposed Overall Completion Date: *06/01/2023*

Implemented (JK - 03/13/2023)

15b Resident abuse-superv plan

2. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On [redacted] staff person A, was assisting resident #1 with a shower. Resident #1 reported staff person A sprayed cold water in the resident's face and across their torso, while laughing and saying, "Isn't this fun, we are having fun.". Resident #1 reported telling staff person A, "no, I am not having fun, I don't like that." Resident #1's tip of nose began to bleed, staff person A requested staff person B's assistance.

Staff person B entered resident #1's room and heard resident#1 telling staff person A, to "stop it, stop it." Staff person B while tending to the resident's nose inquired how it happened, and if was the resident, who appeared upset was, ok? Resident #1 abruptly stated, "NO, NO, I am not ok, my nose is bleeding because [redacted] sprayed me in the face with cold water. Staff person A was observed laughing about the incident. Staff person B, responded with, "we don't spray people in the face with water, it is not ok." Staff person B left the room and staff person provided care to resident #1, as well as other residents in the home.

Staff person B reported returning to resident #1's room between approximately 8:00 or 8:30 p.m. and found resident #1 still upset telling staff person C, about the incident. Resident #1 stated, I am upset. I told staff person A to stop, that I don't like that, but [redacted] just doesn't stop.

Staff person A continued to work unsupervised in the home until 11:00 p.m. Additionally, staff person A continued to work unsupervised, providing direct care services to resident #1 and all residents of the home, on the following dates: [redacted] for evening shift (2:30 p.m. to 11:00p.m.) and [redacted] and [redacted], daylight shift (6:30 a.m. to 3:00 p.m.). On [redacted] staff person A was suspended after being notified by the Departments Regional Office of the allegation of abuse against staff person A.

Plan of Correction ***Accept (JK - 03/02/2023)***

Staff person B did report incident to leadership via email, education provided: mandatory abuse reporter's outline

15b Resident abuse-superv plan (continued)

phone call to DRC or Administrator to report allegation of abuse. Staff person(s) will then be suspended pending investigation outcome. Staff person A should have been suspended [redacted]. By not reporting immediately, staff person A was permitted to work unsupervised.

Reporting abuse starts with phone call to Area Agency on Aging to report incident. Act 13 form is to be completed for AAA(48 hours), with BHSL regional office reportable event form to be submitted via email within 24 hours. Internal investigation begins after reporting.

Staff education provided 1/27/23, 2/1/23, and 2/16/23. Abuse Reporting and Investigation flow chart, Mandatory Abuse Report Form. Staff person B and C received education. See attached.
Resident Right's education to be provided by Ombudsman at employee in-service by 3/31/23.
Abuse Reporting and Mandatory Reporter education training to be provided by Protective Services at employee in-service by 3/31/23. Record of attendance and content will be recorded and submitted to Department.

Administrator, or designee, will audit all allegations of abuse of resident weekly for 9 weeks, then monthly for 2 months. Audits will ensure compliance to 2800.15.b; any allegations of abuse involving residence's staff person, residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident. Any Plan of Supervision must be approved by both, AAA and Department before implementing. Audit began 02/24/23. Audits will be reviewed during Quality Managment meeting.

Resident #1 scheduled discharged from CCM[redacted]
Staff Person A is no longer employed by residence. Last day worked was [redacted].

Licensee's Proposed Overall Completion Date: *07/01/2023*

Implemented (JK - 03/13/2023)

16c Incident reporting

3. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted]., staff person A, was assisting resident #1 with a shower. Resident #1 reported staff person A sprayed cold water in the resident's face and across their torso, while laughing and saying, "Isn't this fun, we are having fun.". Resident #1 reported telling staff person A, "no, I am not having fun, I don't like that." Resident #1's tip of nose began to bleed, staff person A requested staff person B's assistance.

Staff person B entered resident #1's room and heard resident#1 telling staff person A, to "stop it, stop it." Staff person B while tending to the resident's nose inquired how it happened, and if was the resident, who appeared upset was, ok?

Resident #1 abruptly stated, "NO, NO, I am not ok, my nose is bleeding because [redacted] sprayed me in the face with cold water. Staff person A was observed laughing about the incident. Staff person B, responded with, "we don't spray people in the face with water, it is not ok." Staff person B left the room and staff person provided care to resident #1, as well

16c Incident reporting (continued)

as other residents in the home.

Staff person B reported returning to resident #1's room between approximately 8:00 or 8:30 p.m. and found resident #1 still upset telling staff person C, about the incident. Resident #1 stated, I am upset. I told staff person A to stop, that I don't like that, but [redacted] just doesn't stop.

The abuse was not reported to the Department until 1/26/23.

Plan of Correction ***Accept (JK - 03/02/2023)***

Staff person B did report incident to leadership via email, education to mandatory abuse reporter's outline phone call to DRC or Administrator to report allegation of abuse.
Reporting abuse starts with phone call to Area Agency on Aging to report incident. Act 13 form is to be completed for AAA(48 hours), with BHSL regional office reportable event form to be submitted via email within 24 hours. Internal investigation begins after reporting.
Staff education provided 1/27/23, 2/1/23, and 2/16/23. Abuse Reporting and Investigation flow chart, Mandatory Abuse Report Form. Staff person B and C received education. See attached.

Administrator, or designee, will audit all Reportable Incident or Conditions weekly for 9 weeks, then monthly for 2 months to ensure compliance in accordance with PA 2800.16.a., The Residence shall report the incident or condition to the Department's assisted living resident office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department Abuse reporting shall also follow the guidelines in 2800.15. Audit of Reportable Incidents and Conditions began 2/27/23, see attached. Audits will be reviewed during Quality Managment meeting.

Licensee's Proposed Overall Completion Date: *07/01/2023*

Implemented (JK - 03/13/2023)

42b Abuse/Neglect

4. Requirements

2800.
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 [redacted] staff person A, was assisting resident #1 with a shower. Resident #1 reported staff person A sprayed cold water in the resident's face and across their torso, while laughing and saying, "Isn't this fun, we are having fun.". Resident #1 reported telling staff person A, "no, I am not having fun, I don't like that." Resident #1's tip of nose began to bleed, staff person A requested staff person B's assistance.

Staff person B entered resident #1's room and heard resident#1 telling staff person A, to "stop it, stop it." Staff person B while tending to the resident's nose inquired how it happened, and if was the resident, who appeared upset was, ok?

Resident #1 abruptly stated, "NO, NO, I am not ok, my nose is bleeding because [redacted] sprayed me in the face with cold water. Staff person A was observed laughing about the incident. Staff person B, responded with, "we don't spray people in the face with water, it is not ok." Staff person B left the room and staff person provided care to resident #1, as well as other residents in the home.

42b Abuse/Neglect (continued)

Staff person B reported returning to resident #1's room between approximately 8:00 or 8:30 p.m. and found resident #1 still upset telling staff person C, about the incident. Resident #1 stated, I am upset. I told staff person A to stop, that I don't like that, but [redacted] just doesn't stop.

Resident #1 indicated other incidents with staff person A Including:
** In early 2022, staff person A was assisting resident #1 with PT exercises walking the hall. The resident told staff person A, "I walked enough don't want to walk anymore." Staff person A replied, "You have to." I told [redacted], "No, I don't, I don't want to walk any more, I'm tired. Staff person A replied, "If you don't walk, I will throw you in the pond" and the resident responded, "No you're not." I knew staff person A wouldn't, but I didn't think it was funny.[redacted] laughed about it thought it was funny. I did not think staff person A would hurt me, but I did not think it was funny.*
** During November and December of 2022 Resident #1 reported on at least two occasions when staff person A entered resident #1's room and the resident didn't hear the staff. The resident was in their wheelchair with their back facing the door while in their room and was preoccupied. Staff person A approached the resident from behind reporting one occasion where staff person A wrapped [redacted] arms around the resident's shoulders and front torso, in a bear hug, telling the resident [redacted] e was going to throw the resident in the pond and laughed about it.*
** Resident #1 stated that some time in December, staff person A again entered with residents' room came up from behind putting both hands around the resident's neck. The resident stated the staff person A put pressure slightly around the resident's neck. On both occasions, the resident reported being startled and jumped up in chair., yelling at staff person A, "to stop it, and they had startled the resident," the resident stating, "I don't like that, oh you startled me."*

Resident #1 reported, feeling frightened and scared and didn't like it. Resident #1 reported on these occasions, being frightened, and scared, and didn't like it at all. Staff person A was reported to laugh, played it off as just joking with all incidents.

Staff person A admitted that [redacted] threatened to throw residents in the pond; however, [redacted] stated that she was joking.

Plan of Correction ***Accept (JK - 03/02/2023)***

Resident Neglect and Abuse often goes unreported. As mandatory reporters we must ensure residents are treated with dignity and respect, educated on resident rights as a member of our community, and protected by laws of our commonwealth and federal government. State regulatory agencies have set in place a reporting system to investigate elder abuse/neglect. Reporting allegations of neglect or abuse requires timely notification to local Area Agency on Aging, Department of Human Services, and potentially law enforcement.
Timeline and process to report neglect has been reviewed with all staff. Department of Human Services Abuse reporting education has been provided to all staff, staff person B and C have participated in education. Staff education provided 1/27/23, 2/1/23, 2/16/23. Resident Rights, Dignity and Respect, Abuse Prevention and Investigation, Abuse Reporting. See attached.

Ombudsmen Resident Right's education to be provided as employee in-service by 3/31/23.
Abuse Reporting and Mandatory Reporter education training to be provided by Protective Services at employee in-service by 3/31/23. Record of attendance and content will be recorded and submitted to Department.

Administrator or designee will review Advocate(Ombudsmen) flyer, and resident resource posting at 2/22/23 resident council meeting.

42b Abuse/Neglect (continued)

Administrator or designee will privately interview 3 residents a week for 3 months, then 3 residents a month for 3 months to ensure compliance to PA 2800.42.b, A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. Interviews will be questionnaire form beginning 3/1/23; questionnaires will be reviewed during Quality Managment meeting.

Resident #1 scheduled discharged from CCM [redacted].
Staff Person A is no longer employed by residence. Last day worked was [redacted].

Licensee's Proposed Overall Completion Date: *09/01/2023*

Implemented (JK - 03/13/2023)

224a5 Written initial assessment

5. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:
- iv. The individual's medical history, medical conditions, and current medical status and how they impact or interact with the individual's service needs.
- v. The individual's need for supplemental health care services.

Description of Violation

Resident #2 admitted [redacted], with multiple wounds/ulcers on the right coccyx, right heel, left heel, and multiple skin lesions on lower extremities that the residence was not aware of until admission. Upon discharge from the skilled nursing facility, the physician had ordered home health wound care to begin on 11/9/22 by UPMC Home Healthcare North Wound Care with services ordered three times a week and physician visits one time a week and PRN. However, the initial assessment, dated [redacted], does not include the medical condition of the resident, the care services to be provided for the wounds/ulcers, the agency providing the services or frequency of the services.

Plan of Correction ***Accept (JK - 03/02/2023)***

Resident #2 was admitted [redacted] and the initial written assessment was complete by RN on [redacted] as required by regulation. Wound care was accidental omission. Wound care was provided as prescribed by physician 11/9/22, 3 times per week by UPMC Home Healthcare North Wound Care physician visits one time a week and PRN. Resident was admitted to hospital [redacted], resident did not return to CCM. Resident stayed LTC in SNF after short term therapy stay ending [redacted] Resident exceeded AL level of care.

UPMC Home Healthcare Nurse team met with CCM Clinical Leadership 02/13/23 to clarify treatment plan of specific residents. Discussions lead to strategy for best practice to capture responsibilities of residence when prescribed care is being provided. Meeting was held with CCM Director of Resident Care(RN), Resident Support Coordinator(LPN) and 2 CCM staff nurses(RN and LPN). Home Care team was represented by 2 RN Wound Care licensed staff. Wound Care In-service scheduled 3/10/23 for all nursing staff. Record of attendance and content will be recorded and submitted to Department.

Director of Resident Care, or designee, will audit 100% of resident support plans by 3/31/23. Audit of resident support plans began 2/21/23. Audits are not limited to residents who have dressing/wound care or supplemental health care services. Director of Resident Care will review checklist tracking assessment timeline for completion, initial, final, quarterly updates to include change of conditions or services provided to resident.

Audits will be reviewed quarterly in Quality Management Program.

224a5 Written initial assessment (continued)

Staff education provided, See attached.

Licensee's Proposed Overall Completion Date: *03/31/2023*

Implemented (JK - 03/13/2023)