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

September 13, 2023

[redacted]
THE ARBORS AT ST BARNABAS INC
85 CHARITY PLACE
VALENCIA, PA, 16059

RE: THE ARBORS AT ST. BARNABAS
85 CHARITY PLACE
VALENCIA, PA, 16059
LICENSE/COC#: 42309

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/21/2023, 05/19/2023 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: *THE ARBORS AT ST. BARNABAS* **License #**: *42309* **License Expiration**: *11/10/2023*

Address: *85 CHARITY PLACE, VALENCIA, PA 16059*

County: *BUTLER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *THE ARBORS AT ST BARNABAS INC*

Address: *85 CHARITY PLACE, VALENCIA, PA, 16059*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *06/04/2010* **Issued By**: *Adams Township*

Type: *I-1* **Date**: *01/09/2020* **Issued By**: *Adams Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *82* **Waking Staff**: *62*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *05/19/2023*

Inspection Dates and Department Representative

04/21/2023 - On-Site: [redacted]

05/19/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *229* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd* **Capacity**: *47* **Residents Served**: *18*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *52*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *30* **Have Physical Disability**: *0*

Inspections / Reviews

04/21/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/10/2023*

Inspections / Reviews *(continued)*

06/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/22/2023*

06/27/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/29/2023*

08/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/09/2023*

09/13/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *08/10/2023*

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

15b - Supervisor Plan

1. Requirements

2600.
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 [redacted]/23, between [redacted] p.m., and [redacted] p.m., resident #1 had an unwitnessed fall down the five-step stairwell located on the "2 Old Unit" next to resident room #217. Resident #1 had two additional unwitnessed falls on the following [redacted] p.m., to [redacted] a.m., shift. The first of these falls occurred at approximately [redacted] a.m., and the second occurred at approximately [redacted] a.m. The home contacted [redacted] Emergency Medical Services on [redacted]/23, at [redacted] a.m. due to resident #1 "not being [redacted]". Resident #1 was transported to [redacted] Hospital and subsequently admitted with a traumatic subarachnoid hemorrhage without loss of consciousness, and a right patellar fracture. However, the home failed to notify Protective Services.

Plan of Correction ***Accept [redacted] - 06/27/2023)***

Assuming for the sake of this discussion, the validity of the deficiencies noted in the Department of Human Services Licensing Inspection Summary reported to The Arbors at St. Barnabas, Valencia for the inspection on April 21, 2023, which The Arbors does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Valencia as to the validity of the deficiencies noted in the report.

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.
• One 6/14/23, 1:1 education was provided to each current employee involved with care of resident #1 on [redacted]/23 and [redacted]/23 to assure that they are skilled to recognize injuries that may require EMS or hospitalization and the obligation of staff to report injures or possible injuries.
• The administrator and / or designee began education on 6-8-23 on regulation 2600.15.b. indicating that the facility immediately develops and implement a plan of supervision or suspend the staff person involved in the alleged incident of abuse. Education will be complete 6/19/23.
• Additional education on recognizing injuries that may require EMS or hospitalization as well as the obligation of staff to report injuries or possible injuries was initiated by administrator and/ or designee on 6/14/23. Education will be completed by 6/29/23.
• The administrator will continue to monitor all allegations of alleged abuse and assure that the facility immediately develops and implement a plan of supervision or suspend the staff person involved in the alleged incident of abuse, in regards to recognizing injuries that may require EMS or hospitalization as well as the obligation of staff to report injuries or possible injuries, as they arise. Observations of monitoring will be reviewed at Quality Management meeting.

Licensee's Proposed Overall Completion Date: *06/29/2023*

Implemented [redacted] - 08/07/2023)

16c - Written Incident Report

2. Requirements

2600.

16c - Written Incident Report *(continued)*

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).

Description of Violation

On [redacted]/23, between [redacted] p.m., and [redacted] p.m., resident #1 had an unwitnessed fall down the five-step stairwell located on the "2 Old Unit" next to resident room #217. Resident #1 had two additional unwitnessed falls on the following [redacted] p.m., to [redacted] a.m., Shift. The first of these falls occurred at approximately [redacted] a.m., and the second occurred at approximately [redacted] a.m. The home contacted [redacted] Emergency Medical Services on [redacted]/23, at [redacted] a.m. due to resident #1 "not being [redacted] ". Resident #1 was transported to [redacted] Hospital and subsequently admitted with a traumatic subarachnoid hemorrhage without loss of consciousness, and a right patellar fracture. However, the home failed to notify the department.

Plan of Correction ***Accept [redacted] - 06/27/2023)***

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.

• A reportable incident was emailed to DHS on [redacted]/23 which contained information obtained at that time from the hospital nurse caring for resident #1.
• Education was started on 6/8/23 by the administrator and or designee, with all staff on regulation 2600.16 concerning reporting incidents and or conditions to the DHS or the personal care home hotline within 24 hours in a manner designated by the department. This education will be completed by 6/29/23.
• The administrator and / or designee will audit 0-4 reportable incidents monthly to assure requirements for reporting are being met. Results of audit will be reviewed at Quality Management meeting.

Licensee's Proposed Overall Completion Date: *06/29/2023*

Implemented [redacted] - 09/11/2023)

42b - Abuse

3. 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 [redacted]/23, between [redacted] p.m., and [redacted] p.m., resident #1, while ambulating in [redacted] wheelchair, fell down 5 steps in the staircase of the "2 old" unit next to resident room #217. Staff member A, who was the only staff member available on the unit at the time, found Resident #1 at the bottom of the staircase when [redacted] entered the unit to administer medications. Staff member A requested staff member B's assistance with resident #1. The resident was assessed by staff member A and B and assisted back into [redacted] chair. Staff member B indicated that the resident had a skin tear on [redacted] arm that was bleeding, had a flap and needed to be bandaged. Staff member B indicated that the fall may have caused an incident of incontinence as the resident, was scared and had to be changed after the fall which was not within [redacted] baseline. The resident complained of pain in [redacted] knee and was drowsy and went to be early for the resident. On [redacted]/23, during the [redacted] p.m., to [redacted] a.m., shift, resident #1, had two additional unwitnessed falls. The first fall occurred at approximately [redacted] a.m., the second fall occurred at approximately [redacted] a.m. After the first unwitnessed fall staff member C stated that resident #1 was observed to not be at [redacted] base line, was very confused, talking to [redacted], not able to stand well, hallucinating and would not leave [redacted] clothes on. When staff member C discovered resident

42b - Abuse (continued)

#1's second unwitnessed fall the resident was on the floor next to [redacted] bed and according to staff member C, almost looked like [redacted] was just sleeping on the floor with [redacted] pillow and blanket.
On [redacted]/23, at approximately [redacted] a.m., staff member D stated that resident #1 to be very unresponsive to any attempt to get [redacted] attention by staff". Staff member D observed that resident #1 wasn't with it and was continuously rubbing [redacted] left knee, curled up in a fetal position, and mumbling. The resident's knees were very red and there was slight bruising arounder [redacted] one eye. At [redacted] a.m., Emergency Medical Services (EMS) were contacted by the home and arrived at the home at [redacted] a.m. The resident was transported by EMS to [redacted] Hospital. EMS indicated that resident #1 had an "interior hematoma on the right anterior of [redacted] head" and a "contusion on [redacted] head". EMS also indicated a "contusion on the resident's right lower leg" and a "laceration with controlled bleeding and swelling" on resident #1's left knee. The resident was transported by EMS to [redacted] Hospital.
On [redacted]/23, resident #1 was admitted to [redacted] Hospital with a "traumatic subarachnoid hemorrhage without loss of consciousness", and a "right patellar fracture". [redacted] Hospital indicated the external cause of injury was from a "fall from non-moving wheelchair". The home failed to report immediately request EMS upon finding that resident #1 had fallen down the stairway and noting [redacted] injuries and change in mental status. They only requested EMS upon finding that resident #had fallen out of bed and noted bruising near [redacted] eye.

Plan of Correction ***Accept [redacted] - 06/27/2023)***

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

• All direct care staff involved with incident [redacted]/23 and [redacted]/23 were provided with 1:1 education from administrator on 6/1/23 after facility obtaining the licensing summary.
• Starting on 6/8/23 all other staff are being educated on regulations 2600.42b resident's right not to be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. Education will be completed by the administrator and or designee. The education will be completed 6/29/23
• An audit was started on 6/9/23 which will provide confidential interviews with 3 random residents weekly for one month, then will continue monthly thereafter. The administrator and/or designee will complete the audit. Audit results will be reviewed at Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *06/29/2023*

Implemented [redacted] - 09/11/2023)

182c - Medication Administration

4. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

At [redacted] p.m., there were 5 unattended cups of medication belonging to Resident #2 and resident #3 on the brown circular dining room table located in their multiple resident room #[redacted]. Two medication cups each contained 1 unidentified white oblong pill. One medication cup had the letters [redacted] and the other medication cup had the letters [redacted] written on them in marker. However, resident #2's and resident #3's support plans dated [redacted]/22, and [redacted]/22, indicted that resident #2 and resident #3 could not self-administer medication.

Plan of Correction ***Accept [redacted] - 06/27/2023)***

All medications will be administrated as per the activities listed under 2600 182.c based on resident's needs.

182c - Medication Administration (continued)

• On 4/21/23 med tech was provided with 1:1 educated on not leaving medications in residents' room and proper methods on administration.
• On 4/21/23 at [redacted] resident #3 was given the medications as per order.
• On 5/23/23 Education was provided for staff trained to give medications has been educated on 2600.182c. reviewing administrating medications. Education was completed by administrator and/or designee. Education to be completed by 6/29/23.
• On 5/23/23 an audit was initiated which checked 5 random resident's rooms at random times. The audit will be weekly for two months, then will continue monthly thereafter. The administrator and/or designee will complete the audit. The audit will be reviewed at Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *06/29/2023*

Implemented [redacted] - 09/11/2023)

225c - Additional Assessment

5. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's most recent assessment and support plan dated [redacted]/2022, indicated resident #1's level of supervision as "minimal" with a plan of supervision of "resident requires no supervision in the home or when in familiar surroundings, but needs attendance in unfamiliar places". However, multiple staff members indicated that on multiple occasions over the course of the past several months resident #1 exhibited behaviors indicative of "confusion", "hallucinating", "hearing voices", believed "children were stealing [redacted] balls", and that '[redacted] were in [redacted] bed". On [redacted]/23, between [redacted] a.m., and [redacted] p.m., resident #1 fell from [redacted] wheelchair down a flight of five stairs and was subsequently admitted to [redacted] Hospital for the injuries [redacted] sustained from the fall.

Plan of Correction ***Accept [redacted] - 06/27/2023)***

The resident shall have additional assessments if the condition of the resident significantly changes prior to the annual assessment.

• Resident #1 did not return to facility for a significant change assessment to be completed.
• On 6/1/23 Education was provided for staff on 2600 225.c and recognizing significant changes in resident status. Education was completed by administrator and/or designee. Education to be completed by 6/29/23.
• An audit was started on 6/1/23. The audit will check 5 random resident's RASP in comparison to current conditions to assess if a significant change assessment is required. Audit will be weekly for two months. Then will continue monthly thereafter. The administrator and or designee will complete the audit. Audit results will be reviewed at Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *06/29/2023*

225c - Additional Assessment *(continued)*

Implemented ([redacted] - 09/11/2023)