

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

July 21, 2023

[REDACTED], PRESIDENT/CEO
WESBURY UNITED METHODIST COMMUNITY
31 NORTH PARK AVENUE
MEADVILLE, PA, 16335

RE: WESBURY UNITED METHODIST
COMMUNITY
31 NORTH PARK AVENUE
MEADVILLE, PA, 16335
LICENSE/COC#: 44682

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/27/2023 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: WESBURY UNITED METHODIST COMMUNITY **License #:** 44682 **License Expiration:** 03/25/2023
Address: 31 NORTH PARK AVENUE, MEADVILLE, PA 16335
County: CRAWFORD **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** 8143329000 **Email:** lmarsteller@wesbury.com

Legal Entity

Name: WESBURY UNITED METHODIST COMMUNITY
Address: 31 NORTH PARK AVENUE, MEADVILLE, PA, 16335
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP **Date:** 06/03/1997 **Issued By:** Dept. of Labor & Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 41 **Waking Staff:** 31

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 04/27/2023

Inspection Dates and Department Representative

04/27/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 110 **Residents Served:** 40

Secured Dementia Care Unit

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

Hospice

Current Residents: 1

Number of Residents Who:

Receive Supplemental Security Income: 1 **Are 60 Years of Age or Older:** 40
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 1 **Have Physical Disability:** 0

Inspections / Reviews

04/27/2023 - Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 05/22/2023

06/07/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 07/11/2023
Reviewer: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 06/14/2023

Inspections / Reviews (*continued*)

06/24/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/11/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 06/30/2023

07/03/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/11/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 07/11/2023

07/21/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/11/2023

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

On [redacted]/23, staff person A entered resident #1's room to administer evening medications, consisting of 5 pills. Resident #1 usually takes [redacted] medication with applesauce; however, staff person A did not have applesauce or water with [redacted] so resident #1 refused the medication. Staff person A told resident #1 she could chew the medication, then held the resident's chin while tilting [redacted] head back, and put the 5 pills into resident #1's mouth and used [redacted] hand to push the resident's chin up and down, forcing the resident to chew the medication. Staff person A left the room while the resident still had medication in [redacted] mouth and resident #1 found water in [redacted] room and was able to swallow the pills. Resident #1 indicated [redacted] is afraid of staff person A now, and [redacted] takes her cane to bed for protection. Resident #1 reported this incident shortly after it happened on [redacted] 3 to staff person B and staff person C. However, this allegation of abuse was not reported to the local Area Agency on Aging until [redacted]/23.

Plan of Correction

Accept ([redacted] - 07/03/2023)

On 4/14/23 the Administrator contacted protective Services at the local Active Aging Agency, immediately after learning of the abuse allegation. It was not reported to the Administrator on 4/11/23 because the Administrator was off due to Covid. The Nurse Manager removed the staff person from the schedule on 4/12/23 and started an investigation. On 4/12/23, the resident was told that the alleged perpetrator was suspended from work. On 4/14/23 the Administrator was informed of the 4/11/23 allegation, educated the Nurse Manager on the requirement of reporting the incident to Protective Service immediately and to BHSL within 24 hours, all prior to an internal investigation. On 5/30/23, the staff was educated on Abuse and Neglect during an hour long educational session with a Protective Services representative from the Local Active Aging. On 6/5/23, Direct Care staff was further instruction and education was provided by the Administrator and Nurse Manager, and all received copies of "Abuse and Abuse Reporting" on page 181, and "Suspected Resident Abuse Reporting and Investigation Requirements" on page 182 from the Department's RCG.

Ongoing: As of 4/14/23, it shall be the responsibility of all staff/Administrator/Nurse Manager to immediately inform Protective Services at the local Active Aging Agency, of any alleged abuse. As of 6/16/23, the Administrator shall be responsible for reviewing each abuse/neglect allegation and incident report within 24 hours of each occurrence. As of 6/16/23, the Administrator shall then review these weekly with the Nurse Manager and/or nursing staff.

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

Implemented ([redacted] - 07/21/2023)

15d - Resident Abuse-Notification

2. Requirements

2600.

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

15d - Resident Abuse-Notification (continued)

Description of Violation

On 1/23, staff person A entered resident #1's room to administer evening medications, consisting of 5 pills. Resident #1 usually takes medication with applesauce; however, staff person A did not have applesauce or water with so resident #1 refused the medication. Staff person A told resident #1 could chew the medication, then held the resident's chin while tilting head back, and put the 5 pills into resident #1's mouth and used hand to push the resident's chin up and down, forcing the resident to chew the medication. Staff person A left the room while the resident still had medication in mouth and resident #1 found water in room and was able to swallow the pills. Resident #1 indicated is afraid of staff person A now, and takes her cane to bed for protection. Resident #1 reported this incident shortly after it happened on /23 to staff person B and staff person C. However, this allegation of abuse was not reported to the resident's designated person until /23.

Plan of Correction

Accept (SQ - 07/03/2023)

On 4/12/23, the resident who alleged the abuse by the staff person, was notified by the Nurse Manager that was investigating a reported case of alleged Abuse or Neglect or at the very least a Resident's Rights violation. The resident did not want designated person notified as handles most of own affairs and doesn't like bothered due to the fact of having health issues. On 4/14/23 after being told of the alleged Abuse, the Administrator educated the Nurse Manager that the designated person must be notified immediately. On 4/14/23 the designated person was notified by nursing staff. As of 4/14/23, the Nursing staff and/or Administrator is responsible for immediately notifying all designated parties of a report of suspected abuse or neglect. Training by a Protective Services Representative and the Administrator was held on 5/30/23 for all staff to know the proper steps in handling suspected abuse or neglect, including the fact that the designated person must be immediately notified. On 6/5/23, Direct Care staff was further instructed by the Administrator and Nurse Manager, and all received copies of "Abuse and Abuse Reporting" page 181, and "Suspected Resident Abuse Reporting and Investigation Requirements" page 182, from the Department's RCG.

Ongoing: As of 4/14/23, it shall be the Nursing Staff's responsibility to immediately inform the designated party of a report of suspected abuse or neglect. As of 6/16/23, the Administrator shall be responsible for reviewing each abuse/neglect allegation and incident report within 24 hours of each occurrence. As of 6/16/23, the Administrator shall then review these weekly with the Nurse Manager and/or nursing staff.

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

Implemented (- 07/21/2023)

16c - Written Incident Report

3. 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).

Description of Violation

On /23, staff person A entered resident #1's room to administer evening medications, consisting of 5 pills. Resident #1 usually takes medication with applesauce; however, staff person A did not have applesauce or water with so resident #1 refused the medication. Staff person A told resident #1 could chew the medication, then held the resident's chin while tilting head back, and put the 5 pills into resident #1's mouth and used hand to push the resident's chin up and down, forcing the resident to chew the medication. Staff person A left the room while the resident still had medication in mouth and resident #1 found water in room and was able to swallow the pills. Resident #1 indicated is afraid of staff person A now, and takes cane to bed for protection. Resident #1 reported

16c - Written Incident Report (continued)

this incident shortly after it happened on [REDACTED]/23 to staff person B and staff person C. However, this allegation of abuse was not reported to the Department until [REDACTED]/23.

Plan of Correction**Accept (SQ - 07/03/2023)**

On 4/14/23 after the Administrator was informed of the abuse allegation, a written report to the Department was submitted. On 4/14/23 the Administrator informed the Nurse Manager that all direct care nursing staff needed to be re-educated on the mandatory written reporting of any alleged abuse or neglect with-in 24 hours. On 5/30/23 an hour long in-service on Abuse and Neglect was provided to all staff by the Administrator and a Protective Services Representative. This included instruction on mandatory reporting to the department. On 6/5/23, Direct Care staff received further instruction from the Administrator and the Nurse Manager on reporting allegations of abuse to the department within 24 hours. All received copies of the "Abuse and Abuse Reporting" on page 181, and the flow chart Suspected Resident Abuse Reporting and Investigation Requirements on page 182 from the Department's RCG.

Ongoing: As of 4/14/23, it is the responsibility of the Nurse Manager/Nursing Staff to notify the department of any alleged abuse within 24 hours. As of 6/16/23, the Administrator shall be responsible for reviewing each abuse/neglect allegation and incident report within 24 hours of each occurrence. As of 6/16/23 the Administrator shall then review these weekly with the Nurse Manager and/or nursing staff.

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

Implemented [REDACTED] - 07/21/2023)**42b - Abuse****4. 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, staff person A entered resident #1's room to administer evening medications, consisting of 5 pills. Resident #1 usually takes [REDACTED] medication with applesauce; however, staff person A did not have applesauce or water with [REDACTED] so resident #1 refused the medication. Staff person A told resident #1 [REDACTED] could chew the medication, then held the resident's chin while tilting [REDACTED] head back, and put the 5 pills into resident #1's mouth and used [REDACTED] hand to push the resident's chin up and down, forcing the resident to chew the medication. Staff person A left the room while the resident still had medication in [REDACTED] mouth and resident #1 found water in [REDACTED] room and was able to swallow the pills. Resident #1 indicated [REDACTED] is afraid of staff person A now, and [REDACTED] takes [REDACTED] cane to bed for protection.

Plan of Correction**Accept (SQ - 07/03/2023)**


On 4/14/23, the Administrator discussed and educated the Nurse Manager about resident abuse. On 4/14/23 the nurse manager discussed and educated the direct care staff on resident abuse and neglect. On 4/15/23 the alleged perpetrator was terminated from the facility's employment and this was told to the resident. On 5/30/23, all staff was educated on abuse and neglect by a Protective Services Representative from the local Active Aging Agency. This training included discussions on real life examples of abuse and neglect and on 6/5/23, the Administrator and Nurse Manager provided further training on Abuse and Neglect to direct care staff. All received a copy of 2600.42.b discussion points found in the RCG and these were discussed.

Ongoing:

42b - Abuse (continued)

As of 4/14/23, it will be the Nurse Manager's responsibility to provide abuse and neglect training and education for the direct care staff prior to working, as well as throughout the year. A training module on abuse and neglect is part of the required yearly staff training. As of 6/16/23, the Administrator shall be responsible for reviewing each abuse/neglect allegation and incident report within 24 hours of each occurrence. As of 6/16/23, the Administrator shall then review these weekly with the Nurse Manager and/or nursing staff. As of July 1, 2023, the Administrator or designee will privately interview 4 residents a week during the month of July, and then 4 residents a month for the remainder of 2023, to ensure that they are not neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way. The Administrator or designee shall document the being date of interviews and they will be kept and reviewed at the Quality Management meetings.

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

Implemented  - 07/21/2023)