

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

December 11, 2023

[REDACTED], INTERIM EXECUTIVE DIRECTOR
BROOKDALE SENIOR LIVING COMMUNITIES INC
5300 OLD WILLIAM PENN HIGHWAY
EXPORT, PA, 15632

RE: BROOKDALE MURRYSVILLE
5300 OLD WILLIAM PENN HIGHWAY
EXPORT, PA, 15632
LICENSE/COC#: 42868

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/22/2023, 09/25/2023 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: *BROOKDALE MURRYSVILLE* License #: *42868* License Expiration: *02/19/2024*
 Address: *5300 OLD WILLIAM PENN HIGHWAY, EXPORT, PA 15632*
 County: *WESTMORELAND* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *BROOKDALE SENIOR LIVING COMMUNITIES INC*
 Address: *5300 OLD WILLIAM PENN HIGHWAY, EXPORT, PA, 15632*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *12/09/1997* Issued By: *Labor & Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *56* Waking Staff: *42*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Incident* Exit Conference Date: *09/25/2023*

Inspection Dates and Department Representative

09/22/2023 - On-Site: [REDACTED]
 09/25/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *42* Residents Served: *28*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Entire Home* Capacity: *42* Residents Served: *28*

Hospice
 Current Residents: *9*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *28*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *28* Have Physical Disability: *0*

Inspections / Reviews

09/22/2023 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *10/16/2023*

11/15/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *12/08/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/14/2023*

Inspections / Reviews *(continued)*

11/27/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/08/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 12/07/2023

12/11/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/08/2023

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] to [REDACTED], between the hours of [REDACTED] to [REDACTED] during rounds, direct care staff person A reportedly called direct care staff person B to assist with resident #2, who was in a rocking chair naked at the end of a hallway and refusing to leave or get dressed. The resident's clothing was on the floor next to the chair. Direct care staff person B reported upon arrival in hallway, direct care staff person A appeared visibly frustrated and getting loud with the resident. Direct care staff person B reported telling direct care staff A, "I have this, I can tell you're frustrated." However, direct care staff person A ignored direct care staff person B and refused to leave even though resident #2 ignored direct care staff person A. The resident allowed direct care staff person B to wrap a blanket around him/her and walk down hallway towards the resident's room. While walking the resident, direct care staff person A who was on the residents left side, leaned forward so [REDACTED] was face to face with the resident and said, "Damn resident #2's first name, your breath smells like fucking shit." And continued to escort the resident to their bedroom. The allegation of abuse was not reported to the Area Agency on Aging.

Direct care staff person B reported on the morning of [REDACTED], at approximately [REDACTED] direct care staff person A, woke up the residents out of a dead sleep, toileting and dressing them to put back in bed or in chairs. Many would argue with staff person A about getting up and/or would say "NO, I don't need to go pee." "I don't want to get up." "No, leave me sleep", and then tell the residents "You are being ridiculous." The residents reported direct care staff person A was very impatient, rushed, was rough handling them and did not do any of the morning personal care, such as wipe their faces, comb hair or brush their teeth. Direct care staff person A woke up resident #3 and was heard by direct care staff person B telling the resident, "You pissed the bed, and it is disgusting. I need to get you up." Resident #3 told direct care staff person A, "I'm not getting up and refused; however, the resident was told by direct care staff person A, "you are being ridiculous "and proceeded to get the resident up against their will. The allegation of abuse was not reported to the Area Agency on Aging.

Direct care staff person D reported sometime between [REDACTED] and [REDACTED] during the overnight shift beginning on either [REDACTED] or [REDACTED], direct care staff person A was trying to remove resident #2 from a common bathroom and the refusing to leave. The resident is identified with a diagnosis of [REDACTED], has an unsteady gait, and fall risk. Direct care staff person A was in the bathroom trying to verbally coax the resident out; however, the resident was not responding. Direct care staff person D reported direct care staff person A was visibly frustrated with the resident and getting loud. Direct care staff person A tried to physically move the resident out of the room by pushing the resident at the waist from the side and back, while verbally prompting the resident. Resident #2, was heard telling the staff person, "Stop pushing me, you are going to push me over." Eventually, resident #4 left the bathroom with direct care staff person D on his/her own. The allegation of abuse was not reported to the Area Agency on Aging.

Direct care staff person D reported an incident occurring sometime during the middle of the overnight shift on either [REDACTED] or [REDACTED] Resident #2 was jiggling the handle on the laundry room door that was locked, something resident #2 always does. Direct care staff person D reported being in the living room and observed direct care staff person A, walk up to resident #2 and tell the resident to stop; however, the resident continued to jiggle the handle. Direct care staff person A made a fist with [REDACTED] right hand while walking back over to the resident, lifted [REDACTED] fist and

15a Resident Abuse Report (continued)

proceeded to punch/pound the door above the resident yelling, "STOP" then grabbed resident #2's hand and pulled it from the door handle. Interviews indicated resident #2 looked at direct care staff person A with a "look of disgust" on their resident face, however, did not say anything. Direct care staff person A reportedly just walked away. The allegation of abuse was not reported to the Area Agency on Aging.

Plan of Correction

Accept [redacted] - 11/27/2023)

The following is the Plan of Correction for Brookdale Murrysville in regard to the Statement of Deficiency dated November 9, 2023 for partial complaint survey inspection on 9/22/23 and 9/25/23. The Plan of Correction report is not to be construed as an admission of or agreement with, the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

Executive Director (ED) of record at the time of the incident no longer works at the community. An Interim ED replaced previous ED on 8/31/2023 and reported the incident upon finding the paperwork pertinent to the event. Staff person A no longer works at the community as of 9/1/2023.

9/9/2023, 9/11/2023, 9/12/2023, 9/14/2023 Direct care clinical and management associates were retrained by the ED on the community policy regarding suspected abuse and timely notification to the Area Agency on Aging.

10/26/2023 A community retraining was completed for direct care staff and managers by OAPSA representative, Michelle George, from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/ neglect.

To assist with ongoing compliance, the ED or designee will review any allegation of potential incidents of abuse upon notification of the allegation, for one month, and then weekly for two (2) additional months to verify compliance starting November 1, 2023 and ending December 31, 2023.

Thereafter, the ED or designee will conduct monthly reviews of any allegations of abuse for three (3) months to verify compliance. Documentation of interviews will be kept in the ED office.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [redacted] - 12/11/2023)

15b - Supervisor Plan

2. 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] to [redacted] between the hours of [redacted] to [redacted], during rounds, direct care staff person A reportedly called direct care staff person B to assist with resident #2, who was in a rocking chair naked at the end of a hallway and refusing to leave or get dressed. The resident's clothing was on the floor next to the chair. Direct care staff person B reported upon arrival in hallway, direct care staff person A appeared visibly frustrated and getting loud with the resident. Direct care staff person B reported telling direct care staff A, "I have this, I can tell you're frustrated." However, direct care staff person A ignored direct care staff person B and refused to leave even though resident #2

15b - Supervisor Plan (continued)

ignored direct care staff person A. The resident allowed direct care staff person B to wrap a blanket around him/her and walk down hallway towards the resident's room. While walking the resident, direct care staff person A who was on the residents left side, leaned forward so she was face to face with the resident and said, "Damn resident #2's first name, your breath smells like fucking shit." And continued to escort the resident to their bedroom. Direct care staff person A continued to provide personal care services to resident #2 and other residents of the home until the end of [REDACTED] shift at 7:00 a.m.

Direct care staff person B reported on the morning of [REDACTED] at approximately [REDACTED] direct care staff person A, woke up the residents out of a dead sleep, toileting and dressing them to put back in bed or in chairs. Many would argue with staff person A about getting up and/or would say "NO, I don't need to go pee." "I don't want to get up." "No, leave me sleep", and then tell the residents "You are being ridiculous." The residents reported direct care staff person A was very impatient, rushed, was rough handling them and did not do any of the morning personal care, such as wipe their faces, comb hair or brush their teeth. Direct care staff person A woke up resident #3 and was heard by direct care staff person B telling the resident, "You pissed the bed, and it is disgusting. I need to get you up." Resident #3 told direct care staff person A, "I'm not getting up and refused; however, the resident was told by direct care staff person A, "you are being ridiculous "and proceeded to get the resident up against their will. Direct care staff person A continued to provide personal care services to resident #2 and other residents of the home until the end of her shift at 7:00 a.m.

Direct care staff person D reported sometime between [REDACTED] and [REDACTED] during the overnight shift beginning on either [REDACTED] or [REDACTED], direct care staff person A was trying to remove resident #2 from a common bathroom and the refusing to leave. The resident is identified with a diagnosis of [REDACTED], has an unsteady gait, and fall risk. Direct care staff person A was in the bathroom trying to verbally coax the resident out; however, the resident was not responding. Direct care staff person D reported direct care staff person A was visibly frustrated with the resident and getting loud. Direct care staff person A tried to physically move the resident out of the room by pushing the resident at the waist from the side and back, while verbally prompting the resident. Resident #2, was heard telling the staff person, "Stop pushing me, you are going to push me over." Eventually, resident #4 left the bathroom with direct care staff person D on his/her own. Direct care staff person A continued to provide personal care services to resident #2 and other residents of the home until the end of [REDACTED] shift at 7:00 a.m.

Direct care staff person D reported an incident occurring sometime during the middle of the overnight shift on either [REDACTED] Resident #2 was jiggling the handle on the laundry room door that was locked, something resident #2 always does. Direct care staff person D reported being in the living room and observed direct care staff person A, walk up to resident #2 and tell the resident to stop; however, the resident continued to jiggle the handle. Direct care staff person A made a fist with her right hand while walking back over to the resident, lifted her fist and proceeded to punch/pound the door above the resident yelling, "STOP" then grabbed resident #2's hand and pulled it from the door handle. Interviews indicated resident #2 looked at direct care staff person A with a "look of disgust" on their resident face, however, did not say anything. Direct care staff person A reportedly just walked away. Direct care staff person A continued to provide personal care services to resident #2 and other residents of the home until the end of her shift at 7:00 a.m.

Plan of Correction

Accept [REDACTED] - 11/27/2023)

Staff person A no longer works at the community as of 9/1/2023.

9/9/2023, 9/11/2023, 9/12/2023, 9/14/2023 – Direct care clinical and management associates were retrained by the ED on the community policy regarding abuse, including the process to immediately suspend staff accused of alleged abuse until the investigation is completed.

15b - Supervisor Plan (continued)

10/26/2023- A community retraining of direct care clinical and management associates was completed by OAPSA representative, [REDACTED], from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/ neglect. Included in this training was the importance of timely reporting by mandated reporters to verify that when an allegation does occur that the staff person does not have access to residents unless the community has a plan of supervision approved by the Department and Area Agency on Aging.

To assist with ongoing compliance, the ED or designee will review any allegation of potential abuse upon notification of the allegation for one month, and then weekly thereafter for two (2) months to verify.

To assist with ongoing compliance, the ED or designee will review any allegation of a potential incidents of abuse daily for one month, and then weekly for two (2) additional months to verify compliance starting November 1, 2023 and ending December 31, 2023. The monitoring will include the ED reviewing all allegations of abuse to include that a staff person alleged of abuse shall not have access to residents without a plan of supervision approved by the Department and the Area Agency on Aging.

Thereafter, the ED or designee will conduct monthly reviews will be completed thereafter by the ED to verify compliance. Documentation of interviews will be kept in the ED office.

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [REDACTED] - 12/11/2023)

15d - Resident Abuse-Notification

3. 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.

Description of Violation

On [REDACTED] between the hours of [REDACTED], during rounds, direct care staff person A reportedly called direct care staff person B to assist with resident #2, who was in a rocking chair naked at the end of a hallway and refusing to leave or get dressed. The resident's clothing was on the floor next to the chair. Direct care staff person B reported upon arrival in hallway, direct care staff person A appeared visibly frustrated and getting loud with the resident. Direct care staff person B reported telling direct care staff A, "I have this, I can tell you're frustrated." However, direct care staff person A ignored direct care staff person B and refused to leave even though resident #2 ignored direct care staff person A. The resident allowed direct care staff person B to wrap a blanket around him/her and walk down hallway towards the resident's room. While walking the resident, direct care staff person A who was on the residents left side, leaned forward so she was face to face with the resident and said, "Damn resident #2's first name, your breath smells like fucking shit." And continued to escort the resident to their bedroom. The allegation of abuse was not reported to the resident's designated person.

Direct care staff person B reported on the morning of [REDACTED], at approximately [REDACTED], direct care staff person A, woke up the residents out of a dead sleep, toileting and dressing them to put back in bed or in chairs. Many would argue with staff person A about getting up and/or would say "NO, I don't need to go pee." "I don't want to get up." "No, leave me sleep", and then tell the residents "You are being ridiculous." The residents reported direct care staff person A was very impatient, rushed, was rough handling them and did not do any of the morning personal care, such as wipe their faces, comb hair or brush their teeth. Direct care staff person A woke up resident #3 and was heard by direct care staff person B telling the resident, "You pissed the bed, and it is disgusting. I need to get you up." Resident #3 told direct care staff person A, "I'm not getting up and refused; however, the resident was told by direct care staff person A, "you

15d - Resident Abuse-Notification (continued)

are being ridiculous "and proceeded to get the resident up against their will. The allegation of abuse was not reported to the resident's designated persons.

Direct care staff person D reported sometime between [REDACTED] and [REDACTED], during the overnight shift beginning on either [REDACTED] or [REDACTED], direct care staff person A was trying to remove resident #2 from a common bathroom and the refusing to leave. The resident is identified with a diagnosis of dementia, has an unsteady gait, and fall risk. Direct care staff person A was in the bathroom trying to verbally coax the resident out; however, the resident was not responding. Direct care staff person D reported direct care staff person A was visibly frustrated with the resident and getting loud. Direct care staff person A tried to physically move the resident out of the room by pushing the resident at the waist from the side and back, while verbally prompting the resident. Resident #2, was heard telling the staff person, "Stop pushing me, you are going to push me over." Eventually, resident #4 left the bathroom with direct care staff person D on his/her own. The allegation of abuse was not reported to the resident's designated persons.

Direct care staff person D reported an incident occurring sometime during the middle of the overnight shift on either [REDACTED] Resident #2 was jiggling the handle on the laundry room door that was locked, something resident #2 always does. Direct care staff person D reported being in the living room and observed direct care staff person A, walk up to resident #2 and tell the resident to stop; however, the resident continued to jiggle the handle. Direct care staff person A made a fist with her right hand while walking back over to the resident, lifted her fist and proceeded to punch/pound the door above the resident yelling, "STOP" then grabbed resident #2's hand and pulled it from the door handle. Interviews indicated resident #2 looked at direct care staff person A with a "look of disgust" on their resident face, however, did not say anything. Direct care staff person A reportedly just walked away. The allegation of abuse was not reported to the resident's designated person.

Plan of Correction**Directed [REDACTED] - 11/27/2023)**

9/9/2023, 9/11/2023, 9/12/2023, 9/14/2023 – Direct care clinical and management associates were retrained by the ED on the community policy regarding suspected abuse and timely notification to the resident's legal representative. This training included that all residents and their legal representatives, including those that made the notification, are notified. The documentation will be kept in the resident's record.

10/26/2023- A community retraining was completed by OAPSA representative, [REDACTED], from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/ neglect.

To assist with ongoing compliance, the ED or designee will review any allegation of potential incidents of abuse up notification of the allegation for one month, and then weekly for two (2) additional months to verify compliance starting November 15, 2023 and ending January 15, 2023.

Thereafter, the ED or designee will conduct monthly reviews of any allegations of abuse for three (3) months to verify compliance. Documentation of interviews will be kept in the ED office.

Proposed Overall Completion Date: 01/15/2024

DIRECTED

Within 5 calendar days or receipt of the accepted plan of correction the administrator shall notify all residents and their designated persons indicate in the violation of the incidents cited. The administrator shall document the date, who was notified and who made the notifications in each resident's permanent record. 11/27/23 JK

Proposed Overall Completion Date: 12/02/2023

15d - Resident Abuse-Notification (*continued*)

Directed Completion Date: 12/02/2023

Implemented (JK - 12/11/2023)

16c - Written Incident Report

4. 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 [REDACTED] between the hours of [REDACTED], during rounds, direct care staff person A reportedly called direct care staff person B to assist with resident #2, who was in a rocking chair naked at the end of a hallway and refusing to leave or get dressed. The resident's clothing was on the floor next to the chair. Direct care staff person B reported upon arrival in hallway, direct care staff person A appeared visibly frustrated and getting loud with the resident. Direct care staff person B reported telling direct care staff A, "I have this, I can tell you're frustrated." However, direct care staff person A ignored direct care staff person B and refused to leave even though resident #2 ignored direct care staff person A. The resident allowed direct care staff person B to wrap a blanket around him/her and walk down hallway towards the resident's room. While walking the resident, direct care staff person A who was on the residents left side, leaned forward so [REDACTED] was face to face with the resident and said, "Damn resident #2's first name, your breath smells like fucking shit." And continued to escort the resident to their bedroom. This allegation of abuse was not reported to the Department until 9/7/23.

Direct care staff person B reported on the morning of [REDACTED], at approximately [REDACTED] direct care staff person A, woke up the residents out of a dead sleep, toileting and dressing them to put back in bed or in chairs. Many would argue with staff person A about getting up and/or would say "NO, I don't need to go pee." "I don't want to get up." "No, leave me sleep", and then tell the residents "You are being ridiculous." The residents reported direct care staff person A was very impatient, rushed, was rough handling them and did not do any of the morning personal care, such as wipe their faces, comb hair or brush their teeth. Direct care staff person A woke up resident #3 and was heard by direct care staff person B telling the resident, "You pissed the bed, and it is disgusting. I need to get you up." Resident #3 told direct care staff person A, "I'm not getting up and refused; however, the resident was told by direct care staff person A, "you are being ridiculous "and proceeded to get the resident up against their will. This allegation of abuse was not reported to the Department until [REDACTED]

Direct care staff person D reported sometime between [REDACTED] during the overnight shift beginning on either [REDACTED] direct care staff person A was trying to remove resident #2 from a common bathroom and the refusing to leave. The resident is identified with a diagnosis of dementia, has an unsteady gait, and fall risk. Direct care staff person A was in the bathroom trying to verbally coax the resident out; however, the resident was not responding. Direct care staff person D reported direct care staff person A was visibly frustrated with the resident and getting loud. Direct care staff person A tried to physically move the resident out of the room by pushing the resident at the waist from the side and back, while verbally prompting the resident. Resident #2, was heard telling the staff person, "Stop pushing me, you are going to push me over." Eventually, resident #4 left the bathroom with direct care staff person D on his/her own. This allegation of abuse was not reported to the Department until [REDACTED]

Direct care staff person D reported an incident occurring sometime during the middle of the overnight shift on either

16c Written Incident Report (continued)

Resident #2 was jiggling the handle on the laundry room door that was locked, something resident #2 always does. Direct care staff person D reported being in the living room and observed direct care staff person A, walk up to resident #2 and tell the resident to stop; however, the resident continued to jiggle the handle. Direct care staff person A made a fist with her right hand while walking back over to the resident, lifted her fist and proceeded to punch/pound the door above the resident yelling, "STOP" then grabbed resident #2's hand and pulled it from the door handle. Interviews indicated resident #2 looked at direct care staff person A with a "look of disgust" on their resident face, however, did not say anything. Direct care staff person A reportedly just walked away. This allegation of abuse was not reported to the Department until 9/7/23.

Plan of Correction

Accept (- 11/27/2023)

ED on license at the time of the incident no longer works in the community. An Interim ED replaced previous ED on 8/31/2023. Upon finding paperwork pertaining to event, incident was immediately reported on 9/9/2023, 9/11/2023, 9/12/2023, and 9/14/2023 Direct care clinical and management associates were retrained by the ED on the community policy regarding suspected abuse and timely notification to the Department of Human Services Regional Office.

10/26/2023 A community retraining was completed by OAPSA representative, from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/ neglect. To assist with ongoing compliance, the ED or designee will review any allegation of potential abuse upon notification for one month, and then weekly for two (2) additional months to verify compliance starting November 15, 2023 and ending January 15, 2023.

Thereafter, the ED or designee will conduct monthly reviews of any allegation of abuse for three (3) months to verify compliance. Documentation will be kept in the ED office.

Licensee's Proposed Overall Completion Date: 01/15/2024

Implemented (- 12/11/2023)

42b - Abuse

5. 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 between the hours of , during rounds, direct care staff person A reportedly called direct care staff person B to assist with resident #2, who was in a rocking chair naked at the end of a hallway and refusing to leave or get dressed. The resident's clothing was on the floor next to the chair. Direct care staff person B reported upon arrival in hallway, direct care staff person A appeared visibly frustrated and getting loud with the resident. Direct care staff person B reported telling direct care staff A, "I have this, I can tell you're frustrated." However, direct care staff person A ignored direct care staff person B and refused to leave even though resident #2 ignored direct care staff person A. The resident allowed direct care staff person B to wrap a blanket around him/her and walk down hallway towards the resident's room. While walking the resident, direct care staff person A who was on the residents left side, leaned forward so she was face to face with the resident and said, "Damn resident #2's first name, your breath smells like fucking shit." And continued to escort the resident to their bedroom.

Direct care staff person B reported on the morning of , at approximately direct care staff person A, woke up the residents out of a dead sleep, toileting and dressing them to put back in bed or in chairs. Many would

42b - Abuse (continued)

argue with staff person A about getting up and/or would say "NO, I don't need to go pee." "I don't want to get up." "No, leave me sleep", and then tell the residents "You are being ridiculous." The residents reported direct care staff person A was very impatient, rushed, was rough handling them and did not do any of the morning personal care, such as wipe their faces, comb hair or brush their teeth. Direct care staff person A woke up resident #3 and was heard by direct care staff person B telling the resident, "You pissed the bed, and it is disgusting. I need to get you up." Resident #3 told direct care staff person A, "I'm not getting up and refused; however, the resident was told by direct care staff person A, "you are being ridiculous "and proceeded to get the resident up against their will.

Direct care staff person D reported sometime between [REDACTED] during the overnight shift beginning on either 8/16/23 or 8/17/23, direct care staff person A was trying to remove resident #2 from a common bathroom and the refusing to leave. The resident is identified with a diagnosis of dementia, has an unsteady gait, and fall risk. Direct care staff person A was in the bathroom trying to verbally coax the resident out; however, the resident was not responding. Direct care staff person D reported direct care staff person A was visibly frustrated with the resident and getting loud. Direct care staff person A tried to physically move the resident out of the room by pushing the resident at the waist from the side and back, while verbally prompting the resident. Resident #2, was heard telling the staff person, "Stop pushing me, you are going to push me over." Eventually, resident #4 left the bathroom with direct care staff person D on his/her own.

Direct care staff person D reported an incident occurring sometime during the middle of the overnight shift on either [REDACTED] Resident #2 was jiggling the handle on the laundry room door that was locked, something resident #2 always does. Direct care staff person D reported being in the living room and observed direct care staff person A, walk up to resident #2 and tell the resident to stop; however, the resident continued to jiggle the handle. Direct care staff person A made a fist with her right hand while walking back over to the resident, lifted her fist and proceeded to punch/pound the door above the resident yelling, "STOP" then grabbed resident #2's hand and pulled it from the door handle. Interviews indicated resident #2 looked at direct care staff person A with a "look of disgust" on their resident face, however, did not say anything. Direct care staff person A reportedly just walked away.

Plan of Correction**Directed [REDACTED] - 11/27/2023)**

ED on license at the time of the incident no longer works in the community. An Interim ED replaced previous ED on 8/31/2023. Upon finding paperwork pertaining to event, incident was immediately reported on 9/7/2023.

9/9/2023, 9/11/2023, 9/12/2023, 9/14/2023 – Direct care clinical and management associates were retrained by the ED on the community policy regarding suspected abuse and timely notification to the Department of Health.

10/26/2023- A community retraining for direct care clinical and management associates was completed by OAPSA representative, Michelle George, from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/ neglect.

To assist with ongoing compliance, the ED or designee will review any allegation of potential abuse upon notification of the allegation for one month, and then weekly for two (2) additional months starting November 1, 2023. The documentation will be kept in the ED office.

Proposed Overall Completion Date: 12/31/2023

DIRECTED

Within 5 calendar days of the receipt of the accepted plan o correction: The administrator shall privately interview at least three residents a week for three months and three residents a month thereafter to ensure compliance with Regulation 2600.42(b). Documentation of interviews shall be kept. 11/27/23 JK

42b - Abuse (continued)

Directed Completion Date: 12/02/2023

Implemented [REDACTED] 12/11/2023)

42c - Treatment of Residents

6. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED], sometime during the hours between [REDACTED] m., Direct care staff person B had given resident #1 bubble gum. Direct care staff person A and C were in the medication room when direct care staff person B confirmed that resident #1 could have the bubble gum. Direct care staff person A walked over to resident #1, stuck out [REDACTED] hand and demanded the resident spit out the gum, saying the residents name and "spit out the bubble gum!" multiple times. Direct care staff person A put on a rubber glove and motioned as if to reach into the residents mouth to physically remove the gum from resident #1's mouth; however, was stopped by direct care staff person C and told "No, resident #1 is fine and smiling, we just need to keep eye on her." Direct care staff person A continued to tell resident #1 to spit out the gum; however, direct care staff person C reported the resident was not understanding the staff person's directions and wouldn't do it. Interviews indicated direct care staff person A was told multiple times by direct care staff person C "The resident is fine, it is fine."

Plan of Correction

Directed [REDACTED] - 11/27/2023)

ED on license at the time of the incident no longer works in the community. An Interim ED replaced previous ED on [REDACTED]. Upon finding paperwork pertaining to event, incident was immediately reported on 9/7/2023.

Direct care staff person A no longer works at the community.

9/9/2023, 9/11/2023, 9/12/2023, and 9/14/2023 – Direct care clinical and management associates were retrained by the ED on the community policy regarding treating residents with respect and dignity.

10/26/2023- A community retraining for direct care clinical and management staff was completed by OAPSA representative, [REDACTED], from the Westmoreland County Agency on Aging regarding Mandated Reporting of allegations of abuse/neglect.

To assist with ongoing compliance, the ED or designee will review any alleged potential abuse upon notification of the allegation for one month, and then weekly for two (2) additional months. The documentation will be kept in the ED office.

Proposed Overall Completion Date: 12/31/2023

DIRECTED

Within 5 calendar days of the receipt of the accepted plan o correction: The administrator shall privately interview at least three residents a week for three months and three residents a month thereafter to ensure compliance with Regulation 2600.42(c). Documentation of interviews shall be kept. 11/27/23 [REDACTED]

Directed Completion Date: 12/31/2023

Implemented [REDACTED] - 12/11/2023)