

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

January 23, 2024

[REDACTED]  
CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH  
[REDACTED]

RE: CONCORDIA AT VILLA ST. JOSEPH  
PERSONAL CARE  
1040 STATE STREET  
BADEN, PA, 15005  
LICENSE/COC#: 45300

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/07/2023, 11/07/2023, 11/17/2023, 11/22/2023, 11/27/2023, 11/29/2023 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: *CONCORDIA AT VILLA ST. JOSEPH PERSONAL CARE* License #: *45300* License Expiration: *08/16/2024*  
 Address: *1040 STATE STREET, BADEN, PA 15005*  
 County: *BEAVER* Region: *WESTERN*

**Administrator**

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

**Legal Entity**

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*  
 Address: [REDACTED]  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *I-1* Date: *07/09/2021* Issued By: *Baden Borough*  
 Type: *I-2* Date: *07/09/2021* Issued By: *Baden Borough*

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *146* Waking Staff: *110*

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #:  
 Reason: *Complaint, Incident* Exit Conference Date: *11/29/2023*

**Inspection Dates and Department Representative**

*11/07/2023 - On-Site: Desmond Grace, Joe Eveges*  
*11/07/2023 - Off-Site: Desmond Grace*  
*11/17/2023 - Off-Site: Desmond Grace*  
*11/22/2023 - Off-Site: Desmond Grace*  
*11/27/2023 - Off-Site: Desmond Grace*  
*11/29/2023 - Off-Site: Desmond Grace*

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *127* Residents Served: *108*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Memory Care* Capacity: *33* Residents Served: *24*

**Hospice**

Current Residents: *17*

**Number of Residents Who:**

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *108*  
 Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *0*  
 Have Mobility Need: *38* Have Physical Disability: *2*

## Inspections / Reviews

## 11/07/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/31/2023*

## 01/03/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/22/2024*  
Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *01/10/2024*

## 01/11/2024 - POC Submission

Submitted By: [REDACTED] Date Submitted: *01/22/2024*  
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/25/2024*

## 01/23/2024 - Document Submission

Submitted By: [REDACTED] Date Submitted: *01/22/2024*  
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], at approximately [REDACTED] staff person A heard resident [REDACTED] yelling "help! ..., help! ..., Help!". Upon entering resident [REDACTED]'s room, staff person A found resident [REDACTED] lying on the floor near resident [REDACTED]'s feet curled up in a fetal position. Resident [REDACTED] indicated that resident [REDACTED] came into resident [REDACTED]'s room, picked resident [REDACTED] up by the neck, and began choking [REDACTED]. Resident [REDACTED] then pushed resident [REDACTED] against the wall causing resident [REDACTED] to hit [REDACTED] head against the wall before falling to the floor. Both residents were sent to the hospital for observation and testing. However, the home failed to report the incident to the local Area Agency on Aging in accordance with the Older Adult Protective Services Act until [REDACTED] at [REDACTED]

Resident [REDACTED] most recent medical evaluation dated [REDACTED] indicates that the resident has a diagnosis of unspecified dementia requiring the resident to be served in a Secured Dementia Care unit (SDCU). Resident [REDACTED]'s initial medical evaluation, dated [REDACTED] indicates that the resident also has a diagnosis of unspecified dementia requiring the resident to be served in a SDCU. On [REDACTED], at approximately [REDACTED] while residing in the home's SDCU, resident [REDACTED] was found in resident [REDACTED]'s bed without any clothes on and resident [REDACTED] did not have a shirt on. However, the home failed to report the incident to the local Area Agency on Aging in accordance with the Older Adult Protective Services Act.

Repeat Violation: 5/18/22

Plan of Correction

Accept [REDACTED] - 01/11/2024)

Administrator, RCC and Memory Care supervisor implemented a facility wide initial incident report protocol (attachment 1) and posted to direct care staff on [REDACTED]. This protocol outlines incidents that immediately require notification to the administrator, RCC and Memory Care Supervisor. The management team will quickly assess the incident and report any suspected abuse in accordance with the Older Adult Protective Services Act.

During both incidents on [REDACTED] and [REDACTED] direct care staff did immediately intervene and diffused the incidents. [REDACTED] incident, both residents were sent to the hospital to verify no injuries.

Training on abuse reporting (Attachment 2) has been repeated with staff on [REDACTED] by Memory Care Supervisor and RCC. Training on dementia and interventions (Attachment 3) done on [REDACTED] by [REDACTED] (Dementia Specialist). These trainings were to educate staff on interventions for behavior outbursts and how to de-escalate the situations to prevent incidents.

Administrator will perform weekly reviews on all progress notes, incident reports and change in resident conditions to ensure any allegations of abuse are reported in accordance with 2800.15 and 2800.16. Administrator to keep a log of all weekly reviews. Weekly reviews to start on 1-8-2024.

Licensee's Proposed Overall Completion Date: 01/08/2024

Implemented [REDACTED] - 01/23/2024)

16c - Written Incident Report

2. Requirements

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [REDACTED], at approximately [REDACTED] staff person A heard resident #1 yelling "help! ..., help! ..., Help!". Upon entering resident [REDACTED]'s room, staff person A found resident [REDACTED] lying on the floor near resident [REDACTED]'s feet curled up in a fetal position. Resident [REDACTED] indicated that resident [REDACTED] came into resident [REDACTED]'s room, picked resident [REDACTED] up by the neck, and began choking [REDACTED]. Resident [REDACTED] then pushed resident [REDACTED] against the wall causing resident [REDACTED] to hit [REDACTED] head against the wall before falling to the floor. Both residents were sent to the hospital for observation and testing. However, the home failed to report the incident to the Department.

Resident [REDACTED] most recent medical evaluation dated [REDACTED] indicates that the resident has a diagnosis of unspecified dementia requiring the resident to be served in a Secured Dementia Care unit (SDCU). Resident [REDACTED] initial medical evaluation, dated [REDACTED], indicates that the resident also has a diagnosis of unspecified dementia requiring the resident to be served in a SDCU. On [REDACTED], at approximately [REDACTED], while residing in the home's SDCU, resident [REDACTED] was found in resident [REDACTED]'s bed without any clothes on and resident [REDACTED] did not have a shirt on. However, the home failed to report the incident to the Department until [REDACTED].

Repeat Violation: 5/18/22

Plan of Correction

Accept [REDACTED] - 01/11/2024)

Administrator, RCC and Memory Care supervisor implemented a facility wide initial incident report protocol (attachment 1) and posted to direct care staff on [REDACTED]. This protocol outlines incidents that immediately require notification to the administrator, RCC and Memory Care Supervisor. The management team will quickly assess the incident and report any suspected abuse to the Department's personal care regional office or personal care hotline within 24 hours as directed under 2600.16.c

During both incidents on [REDACTED] and [REDACTED] direct care staff did immediately intervened and diffused the incidents. 10/5/2023 incident, both residents were sent to the hospital to verify no injuries.

Training on abuse reporting (Attachment 2) has been repeated with staff on [REDACTED] by Memory Care Supervisor and RCC. Training on dementia and interventions (Attachment 3) done on [REDACTED] by [REDACTED] (Dementia Specialist). These trainings were to educate staff on interventions for behavior outbursts and how to de-escalate the situations to prevent incidents.

Administrator will preform weekly reviews on all progress notes, incident reports and change in resident conditions to ensure any allegations of abuse are reported in accordance with 2800.15 and 2800.16. Administrator to keep a log of all weekly reviews. Weekly reviews to start 1-8-2024.

Licensee's Proposed Overall Completion Date: 01/08/2024

Implemented [REDACTED] - 01/23/2024)

42b - Abuse

3. Requirements

## 42b - Abuse (continued)

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], at approximately [REDACTED] staff person A heard resident #1 yelling "help! ..., help! ..., Help!". Upon entering resident [REDACTED]'s room, staff person A found resident [REDACTED] lying on the floor near resident [REDACTED]'s feet curled up in a fetal position. Resident [REDACTED] indicated that resident [REDACTED] came into resident [REDACTED]'s room, picked resident [REDACTED] up by the neck, and began choking [REDACTED]. Resident [REDACTED] then pushed resident [REDACTED] against the wall causing resident [REDACTED] to hit [REDACTED] head against the wall before falling to the floor. Both residents were sent to the hospital for observation and testing.

Resident [REDACTED]'s most recent assessment and support plan dated [REDACTED], indicates that the resident displays increased aggression and sexual behaviors/contact toward female residents and staff members. It also indicates that resident [REDACTED] is displaying disruptive behavior such as wandering into other resident's rooms and barricading [REDACTED] in [REDACTED] room, direct care staff will re-direct and re-approach as needed. On [REDACTED], at approximately [REDACTED] staff person B overheard resident [REDACTED] and resident [REDACTED] talking loudly while walking down the hallway. Staff person B ran down the hall to investigate and found resident [REDACTED] attempting to stop resident [REDACTED] from entering [REDACTED] bedroom. Resident [REDACTED] punched resident [REDACTED] in the face twice causing the resident to fall to the ground. While resident [REDACTED] was on the ground, resident [REDACTED] used resident [REDACTED]'s wheeled walker and pinned the resident to the floor while hitting and kicking the resident until staff intervened.

Resident [REDACTED]'s most recent medical evaluation dated [REDACTED] indicates that the resident has a diagnosis of unspecified dementia requiring the resident to be served in a Secured Dementia Care unit (SDCU). Resident [REDACTED]'s initial medical evaluation, dated [REDACTED], indicates that the resident also has a diagnosis of unspecified dementia requiring the resident to be served in a SDCU. Between [REDACTED] and [REDACTED] multiple progress notes and staff interviews indicated that resident [REDACTED] was displaying increased sexually inappropriate, instigative/authoritative behaviors and bully like behaviors toward peers and would become physically aggressive toward others. The home failed to properly supervise resident [REDACTED] and resident [REDACTED] leading to multiple incidents to include the following:

- On [REDACTED] at approximately [REDACTED] resident [REDACTED] stood blocking the door to resident [REDACTED] bedroom and refused to allow staff to enter. Resident [REDACTED] indicated to staff that [REDACTED] didn't know where resident [REDACTED] was and that the resident had been gone from the home for hours. After staff including staff person C, looked in all of the other bedrooms and common areas and couldn't locate resident [REDACTED], they returned to resident [REDACTED] room to unlock the door with a key and found resident [REDACTED] in resident [REDACTED] room seated on the couch out of sight of staff from the door.
- On [REDACTED] at approximately [REDACTED] multiple staff to include direct care staff person D asked to enter resident [REDACTED]'s bedroom to see if resident [REDACTED] was in the room. Resident [REDACTED] held tightly onto the door handle and wouldn't allow staff to enter to check for resident [REDACTED] while telling staff that resident [REDACTED] wasn't in the bedroom and had left for the weekend. When the staff eventually got around resident [REDACTED] they found resident [REDACTED] in resident [REDACTED] bed.
- On [REDACTED] at approximately [REDACTED] resident [REDACTED] was found in resident [REDACTED] bed without any clothes on and resident [REDACTED] did not have a shirt on.
- On [REDACTED] at [REDACTED] staff person C found resident [REDACTED] in resident [REDACTED]'s bedroom. Resident [REDACTED] was standing by the door when staff entered and resident [REDACTED] was in bed undressed with only underwear on. Staff attempted to redirect resident [REDACTED] however, the resident refused to leave resident [REDACTED] bedroom. Staff were eventually able to redirect resident [REDACTED] from resident [REDACTED]'s bedroom. However, resident [REDACTED] made multiple attempts to re-enter resident [REDACTED] room on same day.

## 42b - Abuse (continued)

**Plan of Correction****Accept** [REDACTED] - 01/11/2024)

Resident [REDACTED] placed in an alternative setting on [REDACTED].

On [REDACTED], a full time Memory Care Supervisor was hired to increase the level of supervision and provide education and guidance in the memory care unit.

Facility managers on leadership team are rotating supervision on weekends (attachment 4) and have added a rotation on evenings (Attachment 5) to increase supervision as these times have been a trend for timing of these incidents.

24 hour shift report (Attachment 6) and an over night round list report (Attachment 7) was implemented on [REDACTED] for increased communication between care staff and resident needs. The reports are turned into the RCC for review the next morning.

Administrator or designee will privately interview [REDACTED] residents per week for 2 months, then monthly thereafter, regarding treatment by other residents and staff. Documentation of reviews shall be kept and reviewed at quality management plan review meetings by leadership team. Reviews to start 1-8-2024.

**Licensee's Proposed Overall Completion Date: 01/08/2024**

**Implemented** [REDACTED] - 01/23/2024)