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

March 26, 2024

[redacted], BOARD PRESIDENT
ELIZABETH SETON CARE CENTER
129 DEPAUL CENTER ROAD
GREENSBURG, PA, 15601

RE: ELIZABETH SETON MEMORY CARE CENTER
129 DEPAUL CENTER ROAD
GREENSBURG, PA, 15601
LICENSE/COC#: 44577

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/02/2024, 02/06/2024 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**: *ELIZABETH SETON MEMORY CARE CENTER* **License #**: *44577* **License Expiration**: *09/14/2024*

**Address**: *129 DEPAUL CENTER ROAD, GREENSBURG, PA 15601*

**County**: *WESTMORELAND* **Region**: *WESTERN*

## Administrator

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

## Legal Entity

**Name**: *ELIZABETH SETON CARE CENTER*

**Address**: *129 DEPAUL CENTER ROAD, GREENSBURG, PA, 15601*

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

## Certificate(s) of Occupancy

**Type**: *C-2 LP* **Date**: *09/27/1999* **Issued By**: *DEPT L & I*

## Staffing Hours

**Resident Support Staff**: *0* **Total Daily Staff**: *16* **Waking Staff**: *12*

## Inspection Information

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

**Reason**: *Renewal* **Exit Conference Date**: *02/20/2024*

## Inspection Dates and Department Representative

*02/02/2024 - On-Site* [redacted]

*02/06/2024 - On-Site* [redacted]

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity**: *24* **Residents Served**: *8*

### Secured Dementia Care Unit

**In Home**: *Yes* **Area**: *Seton Memory* **Capacity**: *24* **Residents Served**: *8*

### Hospice

**Current Residents**: *7*

### Number of Residents Who:

**Receive Supplemental Security Income**: *0* **Are 60 Years of Age or Older**: *8*

**Diagnosed with Mental Illness**: *5* **Diagnosed with Intellectual Disability**: *0*

**Have Mobility Need**: *8* **Have Physical Disability**: *0*

# Inspections / Reviews

### 02/02/2024 Full

**Lead Inspector**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/03/2024*

### 03/05/2024 - POC Submission

**Submitted By**: [redacted] **Date Submitted**: *03/20/2024*

**Reviewer**: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/12/2024*

## Inspections / Reviews *(continued)*

**03/19/2024 POC Submission**

**Submitted By:** [redacted] **Date Submitted:** *03/20/2024*

**Reviewer:** [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/12/2024*

**03/26/2024 Document Submission**

**Submitted By:** [redacted] **Date Submitted:** *03/20/2024*

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

## 51 - Criminal Background Check

**1. Requirements**

2600.
51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

**Description of Violation**

*Direct Care Staff Person A was hired [redacted]; however, the home did not complete a Pennsylvania State Police Criminal background history check.*

**Plan of Correction** ***Accept ([redacted] - 03/19/2024)***

*On 2/6/24, [redacted], Administrative Assistant, submitted a PSP Criminal background check for Staff Person A.*
*The incorrect background check in employee A's file was obtained from their file while employed with the Sisters of Charity who did not use the Pennsylvania State Police Criminal background history check.*
*The correct PSP Clearance was received on 2/8/24 and was placed in the employee A's file.*
*Going forward the ARCD, who completes hiring documents, will not rely on prior employer's clearances and will always request the correct PSP Clearance for all new hires and volunteers.*
*3/11/24 the Interim Administrator audited the employee files to ensure each employee has a Criminal History Background Check completed. In addition, the The new hire Employee File Checklist was updated to include PSP Criminal background check requirement.*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 65g - Annual Training Content

**2. Requirements**

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

**Description of Violation**

*Ancillary Staff Person B, hired [redacted], did not receive training in emergency preparedness procedures and recognition and response to crisis and emergency situations, resident rights, the Older Adult Protective Services act, or falls and accident prevention during the 1/1/23 to 12/31/23 annual training year.*

**Plan of Correction** ***Accept ([redacted] - 03/19/2024)***

*Interim Administrator immediately began to develop a training binder which includes emergency preparedness procedures and recognition and response to crisis and emergency situations, resident rights, the Older Adult Protective Services act, falls and accident prevention [for training year 2024]. Each employee & volunteer will be trained at the time of hire/start of volunteer service and then will be trained annually by either the Administrator, ARCD, or department head for ancillary staff. Once the training material is accepted by the state, we will begin this training and have all ancillary/ volunteers completed within 30 days all of ESMCC employees are completed all ready.*
*Quality management meeting was held on 3/12/24. Discussion included development of Staff Training Binder and schedule of training.*

## 65g - Annual Training Content *(continued)*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 65i - Training Record

**3. Requirements**

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

**Description of Violation**

*The home's record of annual trainings, completed 1/1/23 to 12/31/23 for multiple staff, including Staff Person A, hired 10/18/21; Staff Person C, hired 3/17/22; and Staff Person D, hired 1/4/22, did not include the dates the trainings were completed.*

**Plan of Correction** ***Accept [redacted] - 03/19/2024)***

*On 2/6/24 the Interim Administrator revised the annual training log to include the date, an employee signature line, and a line for the employee to enter the date they completed the training. The employee will sign and date the training log for each monthly training completed by the employee. The Interim Administrator will review the training log monthly to ensure proper completion.*
*At the Quality Management meeting held on 3/12/24, discussion was held regarding the requirement for monthly review of staff training documentation and the proper completion of all training logs.*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 82a - Poisonous Materials

**4. Requirements**

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

**Description of Violation**

*At 10:30 am, the following containers were stored on the shelf of the lower-level housekeeping storage room: an 800 ml, clear spray bottle, labeled floor stripper, that was ¾'s full of a burnt orange-colored liquid; an 800 ml, clear spray bottle, labeled Lestoil, that was ¾-filled with a dark yellow-colored liquid; a 3-gallon, clear container of surface remover that was ½-filled with clear liquid; and a 3-gallon unlabeled, clear container filled with clear liquid. However, the liquids did not have the poison labels indicating the poison precaution by the manufacturer.*

**Plan of Correction** ***Accept [redacted] - 03/19/2024)***

*2/2/24 the Interim Administrator verified that the unlabeled containers were discarded.*
**Current staff will be educated regarding labeling & storage of poisonous materials by Interim Administrator within 30 days of acceptance of the Plan of Correction.*
**Staff training will include that all poisonous materials will be properly stored in their original labeled containers, and materials not in original containers will include the original product labels.*

## 82a Poisonous Materials (continued)

** Review of poisonous materials was discussed at the Quality Management meeting held on 3/12/24. A monthly checklist for chemicals/poisonous materials has been developed and will be instituted on 4/1/24.*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 85d - Trash Receptacles

**5. Requirements**

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

**Description of Violation**

*At 12:30 pm, a large 55 gallon trash can was ½ filled with food and trash in the dishwashing room of the main kitchen; however, the trash can was not actively being used by staff and was uncovered.*

*At 12:45 pm, the trash can in the spa bathroom of the home was ¼ filled with paper trash and other debris; however, the trash can did not have a lid and was uncovered.*

**Plan of Correction** ***Accept ([redacted] - 03/05/2024)***

*On 2/2/24, the employee in the Dietary department immediately placed the lid on the trash receptacle. On 2/8/24, the Interim Administrator ordered a new trash receptacle with an attached lid for the spa bathroom of the home. The new trash receptacle was placed in that bathroom on 2/12/24. A laminated sign requiring that the lid must remain on trash receptacles has been placed in both areas.*

**Licensee's Proposed Overall Completion Date:** *03/01/2024*

***Implemented ([redacted] - 03/26/2024)***

## 132g - Fire Drills Days/Times

**6. Requirements**

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

**Description of Violation**

*The home's fire drills, held during sleeping hours from 12/1/22 to 2/6/24, were completed on 12/16/22 at 6:22 a.m., 5/10/23 at 6:36 a.m., and 10/20/23 at 6:28 a.m.; however, the fire drills were conducted during the same shift and around the same time of day.*

**Plan of Correction** ***Accept [redacted] - 03/19/2024)***

*On 2/6/24 the Interim Administrator spoke with the Provincial Superior of the Sisters of Charity of Seton Hill to emphasize the requirement that a fire drill must be conducted twice a year during sleeping hours. A fire drill will be conducted during these hours in April 2024 and at least twice a year thereafter. Staff and residents will not be notified of the date and time of the drill. A log will be kept of all fire drills.*
*Monthly Fire Drill Log is being completed by Interim Administrator. Copy of the log will be sent upon acceptance of POC.*

## *132g Fire Drills Days/Times (continued)*

*A fire drill will be conducted at various times every 6 months between the hours of 11PM and 6AM beginning April 2024.*

*Monthly Fire drill schedule and log was discussed at the Quality Management meeting held on 3/12/24.*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 184a - Resident's Meds Labeled

**7. Requirements**

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

**Description of Violation**

*Resident #1 is prescribed [redacted] by mouth three times per day as needed for anxiety. However, the medication's pharmacy label indicated the medication be administered three times daily.*

**Plan of Correction** ***Accept [redacted] 03/05/2024)***

*On 2/2/24 the ARCD immediately placed a change of direction label on the medication for Resident #1. ARCD contacted Hospice to request a new medication refill with the proper label. The new medication was placed in the med cart on 2/27/24. The med cart will be audited monthly by two Medication Technicians.*

**Licensee's Proposed Overall Completion Date:** *03/01/2024*

***Implemented ([redacted] - 03/26/2024)***

## 185a - Implement Storage Procedures

**8. Requirements**

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

**Description of Violation**

*Resident #2 is prescribed blood sugar checks as needed for [redacted]; however, the resident's blood sugar testing strips expired 1/31/24.*

**Plan of Correction** ***Accept ([redacted] - 03/05/2024)***

*On 2/2/24 the ARCD removed the expired strips from the cart and discarded them. She contacted Hospice to request a new order to discontinue the order for use of the blood sugar checks for Resident #2 because they have not been needed for in excess of 6 months. The Hospice nurse provided this order to discontinue blood sugar checks on 2/5/24. The med cart will be audited monthly by two Medication Technicians.*

**Licensee's Proposed Overall Completion Date:** *03/01/2024*

***Implemented [redacted] - 03/26/2024)***

## 225c - Additional Assessment

**9. Requirements**

2600.

## 225c - Additional Assessment *(continued)*

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

**Description of Violation**

*Resident #1's assessment of care needs, completed [redacted] does not address the resident care needs for bed alarms/fall mats currently installed at the resident's bed side.*

**Plan of Correction** ***Accept ([redacted] - 03/19/2024)***

*On 2/6/24 the Interim Administrator added the bed alarm to the Resident #1's RASP. Resident #1 DOES NOT have fall mats installed at their bed side.*
*The Interim Administrator and the ARCD will review each other's completed RASPs to ensure all care needs are documented.*
*Audit of the RASPs was completed by Interim Administrator on 3/7/24 to ensure that all diagnoses and medical needs have been identified and addressed.*
*An audit log has been developed and will be provided upon approval of POC.*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented [redacted] - 03/26/2024)***

## 227g -Support Plan Signatures

**10. Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

**Description of Violation**

*Resident #3's assessment and support plan, completed [redacted] is not signed, nor is there an indication of the resident's inability to sign. The signature of the resident's designee is not dated.*

**Plan of Correction** ***Accept ([redacted] - 03/19/2024)***

*On 2/6/24 the Interim Administrator checked the "resident unable to sign" box on the RASP for Resident #3, and noted that it was a late entry on behalf of the Interim Administrator. The Interim Administrator and the ARCD will review each other's completed RASPs to ensure the resident and/or their designee has signed and dated the form. When the resident is unable to sign, the appropriate box will be checked.*
*Audit of RASPs was completed by Interim Administrator on 3/7/24 for all current residents to ensure that the plans contain the required signatures and/or notations of each resident's inability or refusal to sign (if applicable).*

**Licensee's Proposed Overall Completion Date:** *03/12/2024*

***Implemented ([redacted] - 03/26/2024)***