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

March 12, 2024

PRESBYTERIAN SENIORCARE

RE: WOODSIDE PLACE OF WASHINGTON OF PRESBYTERIAN SENIORCARE
954 REDSTONE ROAD
WASHINGTON, PA, 15301
LICENSE/COC#: 45099

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/23/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *WOODSIDE PLACE OF WASHINGTON OF PRESBYTERIAN SENIORCARE* **License #**: *45099* **License Expiration**: *02/24/2024*

Address: *954 REDSTONE ROAD, WASHINGTON, PA 15301*

County: *WASHINGTON* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *PRESBYTERIAN SENIORCARE*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *12/12/2019* **Issued By**: *South Strabane Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *72* **Waking Staff**: *54*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/23/2024*

Inspection Dates and Department Representative

02/23/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* **Residents Served**: *36*

Special Care Unit

In Home: *Yes* **Area**: *Entire Residence* **Capacity**: *36* **Residents Served**: *36*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *0*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *36* **Have Physical Disability**: *0*

Inspections / Reviews

02/23/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/14/2024*

03/06/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/12/2024*
Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/13/2024*

Inspections / Reviews *(continued)*

03/12/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *03/12/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *03/19/2024*

03/12/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *03/12/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

15a Resident abuse report

1. Requirements

2800.
15.a. The residence 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 at approximately direct care staff person A was overheard by direct care staff person B yelling at resident to sit up in wheelchair. Direct care staff person B then witnessed direct care staff person A dragging resident , who was clinging to the armrests of wheelchair with backside sitting on the leg rests and feet and legs dragging on the floor to the door threshold of resident room in the Countryside Neighborhood. Direct care staff person B called direct care staff person C for assistance and then both staff person's witnessed direct care staff person A tell resident , "I know you can do it, you've done it before, crawl on your hands and knees" while directing resident towards bed. Direct care staff persons A, B and C then attempted to lift resident from the ground to wheelchair and direct care staff person A aggressively pulled the rear collar of resident sweatshirt taut against the resident's throat and called resident an and told the resident to "Quit behaving like an ." Direct care staff person B and direct care staff person C both indicated resident asked direct care staff person A to leave alone and get away from and direct care staff person A ignored the request. Once resident , was seated in bed, direct care staff person A was witnessed aggressively throwing the resident's legs into the bed in frustration by direct care staff person B and direct care staff person C. Direct care staff person A aggressively yanked the resident's sweatpants from legs and remarked "You smell like pee because you can't take yourself to the bathroom" to resident . Direct care staff person B indicated resident appeared angry and clenched fist and was taunted by direct care staff person A who stated, "Go ahead and do it". However, the allegations of physical and verbal abuse were not immediately reported to the Department of Aging in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and 6 Pa. Code Sections 15.21 – 15.27 (relating to reporting suspected abuse) and was not reported to the Department of Aging in writing until at and verbally on at

Plan of Correction ***Accept 03/12/2024)***

Incident was reported to RN Resident Services Coordinator at on . RN was unsure if the Department of Aging was open at that time and subsequently reported the following day. To prevent recurrence RN was in-serviced by the Administrator on proper reporting protocol in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 – 10225.707) and 6 Pa. Code Sections 15.21 – 15.27 and was provided with the 24 hour hotline number for the Department of Aging. 2800.15A components will be discussed in our Quality Assurance and Improvement meeting. The Administrator has created an abuse reporting protocol and all staff members have been trained by the Administrator. An abuse reporting audit checklist has been created by The Administrator and all abuse reports will be audited utilizing the checklist starting on and moving forward from this date per occurrence. Table-top drills will be conducted by the Administrator on the first Monday of every month during team huddles. These drills will present the team with a scenario involving abuse and team members will be required to respond to the hypothetical scenario. These table-tops will begin on . Records of attendance and participation will be kept on file in the Administrator's office.

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

Implemented 03/12/2024)

42b Abuse/Neglect

2. Requirements

2800.
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 at approximately direct care staff person A was overheard by direct care staff person B yelling at resident to sit up in wheelchair. Direct care staff person B then witnessed direct care staff person A dragging resident who was clinging to the armrests of wheelchair with backside sitting on the leg rests and feet and legs dragging on the floor to the door threshold of resident room in the Countryside Neighborhood. Direct care staff person B called direct care staff person C for assistance and then both staff person's witnessed direct care staff person A tell resident , "I know you can do it, you've done it before, crawl on your hands and knees" while directing resident towards bed. Direct care staff persons A, B and C then attempted to lift resident from the ground to his wheelchair and direct care staff person A aggressively pulled the rear collar of resident sweatshirt taut against the resident's throat and called resident an and told the resident to "Quit behaving like an Direct care staff person B and direct care staff person C both indicated resident asked direct care staff person A to leave alone and get away from and direct care staff person A ignored the request. Once resident , was seated in bed, direct care staff person A was witnessed aggressively throwing the resident's legs into the bed in frustration by direct care staff person B and direct care staff person C. Direct care staff person A aggressively yanked the resident's sweatpants from legs and remarked "You smell like pee because you can't take yourself to the bathroom" to resident Direct care staff person B indicated resident appeared angry and clenched fist, and was taunted by direct care staff person A who stated, "Go ahead and do it".

Plan of Correction ***Directed - 03/12/2024)***

Staff person A was immediately suspended and told to leave the building. Staff person A remained suspended until investigation was completed. Staff person A was terminated on following investigation. All staff were provided with education on directing them to immediately report any instance of verbal or physical abuse to the supervisor on duty to maintain resident safety and prevent a situation from escalating. All supervisors were provided with education on steps to take following a report of verbal or physical abuse on . All staff are currently educated on abuse prevention and reporting upon hire and annually. Components of 2800.42B will be discussed in our Quality Assurance and Improvement meeting. The Administrator has created a simple and easy to answer interview questionnaire, being mindful that all of the residents in the community have a dementia diagnosis and some level of cognitive impairment. The Administrator will interview 3 residents per week for one month. then 3 residents quarterly for a year. Interviews will be kept on file in the Administrator's office.

Proposed Overall Completion Date: 03/12/2024

DIRECTED
Within 1 calendar day of the receipt of the accepted plan of correction: The Administrator shall start the private resident interviews. 3/12/24

Directed Completion Date: *03/13/2024*

Implemented 03/12/2024)