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

July 22, 2024

[redacted]
FDG CB OPCO LLC
[redacted]

RE: ATRIA AT CRANBERRY WOODS
3020 FAIRPORT LANE
CRANBERRY TOWNSHIP, PA, 16066
LICENSE/COC#: 45268

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/31/2024 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: *ATRIA AT CRANBERRY WOODS* **License #**: *45268* **License Expiration**: *04/13/2025*

Address: *3020 FAIRPORT LANE, CRANBERRY TOWNSHIP, PA 16066*

County: *BUTLER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *FDG CB OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/29/2021* **Issued By**: *Cranberry Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *06/13/2024*

Inspection Dates and Department Representative

05/31/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* **Residents Served**: *58*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *3rd floor* **Capacity**: *41* **Residents Served**: *17*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *58*

Diagnosed with Mental Illness: *2*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *18*

Have Physical Disability: *0*

Inspections / Reviews

05/31/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2024*

Inspections / Reviews *(continued)*

06/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/03/2024*

06/27/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/15/2024*

07/22/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/22/2024*

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

16c - Written Incident Report

1. 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 approximately [redacted], resident [redacted] invaded the personal space of resident [redacted] staff attempts to redirect [redacted] were not successful, the incident escalated resulting in resident [redacted] pushing resident [redacted]. However, the home failed to report the incident to the department.

In approximately the first two weeks of February residents [redacted] and [redacted] were engaged in open mouth [redacted] with [redacted] rubbing the crouch of [redacted] However, the home failed to notify the department.

Plan of Correction ***Accept [redacted] 06/26/2024)***

· Resident [redacted] was sent to the hospital on [redacted] and was discharged to a different facility. Resident [redacted] will not be returning to Community.
· Incident involving Resident [redacted] and Resident [redacted] was reported to the Department on [redacted]. The incident involving Resident [redacted] and Resident [redacted] was not reported, as the Community determined after investigation that no abuse occurred (only a [redacted] was reported to Executive Director, and both the residents and their families consented to the event).
· Executive Director/Designee will retrain all staff on 2600.16c, including incident and abuse reporting requirements, on or before 7/27/2024.
· Executive Director/Designee will re-educate all Department Directors on process of reporting incidents to the Department of Health and Senior Services within 24 hours on or before 7/15/2024.
· Resident Services Director and/or Executive Director/Designee will perform weekly audits for the next 90 days beginning 6/28/24 to ensure incidents and abuse are being reported timely.

Licensee's Proposed Overall Completion Date: *07/27/2024*

Implemented [redacted] 07/22/2024)

42b - Abuse

2. 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

Resident [redacted] assessment and support plan completed on [redacted], indicated an assessed mental health need of resident [redacted] as "resident has no mental health needs and a plan to meet this service need of "resident [redacted] has no mental health needs. Resident [redacted] has engaged in multiple incidents of verbal and physical aggression towards staff members and residents to include on approximately [redacted], resident [redacted] became aggressive and agitated, staff attempts at redirection resulted in resident [redacted] becoming more agitated. On approximately [redacted], 9:50 p.m., resident [redacted] became very aggressive and combative with staff, staff members' attempted redirections were not successful. On approximately [redacted], 10:45 p.m., resident [redacted] became verbally aggressive with staff and began yelling at staff, staff attempts at redirection were not successful. On approximately [redacted], 6:30 p.m., resident [redacted] invaded the personal space of a staff member screaming at [redacted] let me out. On approximately [redacted], resident [redacted] exhibited dangerous behavior and increased aggression requiring resident [redacted] to be transported to Cranberry UPMC Passavant Hospital. On

42b - Abuse (continued)

approximately [redacted], resident [redacted] became physically aggressive while attempting to enter onto the elevator and struck a personal care giver in the face. On approximately [redacted], resident [redacted] became physically aggressive with staff, kicking and pushing staff members. On approximately [redacted], resident [redacted] became aggressive hitting the elevators with [redacted] fists and attempted to push / pull another resident. Resident [redacted] became aggressive with staff when they attempted to intervene, pushing a staff member into a wall and screaming who in the [redacted] do you think you are. On approximately [redacted], resident [redacted] became verbally aggressive with staff members and then pushed two [redacted] residents, at approximately 11:00 p.m., on that same day resident [redacted] became verbally aggressive with staff members and began beating on the elevator doors. On approximately [redacted] resident [redacted] attempted to enlist the assistance of multiple other residents to partake in a planned elopement, upon staff attempting to redirect resident [redacted] became physically aggressive hitting and pushing staff members. On approximately [redacted], resident [redacted] invaded the personal space of resident [redacted], staff member redirection attempts were not successful, the incident escalated resulting in resident [redacted] pushing resident [redacted] On approximately [redacted] resident [redacted] became physically aggressive with resident [redacted] pushing [redacted] into a wall causing resident [redacted] to fall onto the floor. Resident [redacted] cried out "Ow!" in pain and experienced significant fear as [redacted] crawled on [redacted] hands and knees in an attempt to remove [redacted] from resident [redacted] proximity. On [redacted], an updated assessment of resident [redacted] mental health needs and a plan to meet the assessed mental health needs of resident [redacted] was made. Resident [redacted] mental health needs were assessed as having "no mental health needs" with an updated plan of service provision to meet this need as "resident [redacted] often gets agitated, wanting [redacted] to pick [redacted] up has been difficult to redirect 30-day notice issued requested family provide one-on-one care. Resident [redacted] family declined to provide one-on-one care to marry. However, resident [redacted] most current assessment and support plan regarding the supervision needs of resident [redacted] remained "does not require supervision at the community or outside the community with a plan to meet this supervision need of "staff will supervise while in the community family will supervise while out of the community". The assessment and support plan regarding resident [redacted] supervision needs also indicated that zero additional minutes of supervision would be provided to resident [redacted] On approximately [redacted] at resident [redacted] pushed resident [redacted] causing resident [redacted] to cry for approximately 30 minutes and repeatedly state I am scared.

On [redacted], 12:40 a.m., resident [redacted] entered resident [redacted] room, opening resident [redacted] dresser's drawers and moving [redacted] personal clothing items around in [redacted] dresser. On approximately [redacted] in response to this incident, resident [redacted] Power of Attorney requested resident [redacted] door to be locked during sleeping hours. The home implemented a policy requiring resident [redacted] private room's door to be locked during sleeping hours. On [redacted], at approximately 12:06 a.m., staff member A entered resident [redacted] room for a well check and upon exiting resident [redacted] room failed to lock [redacted] private room's door. At approximately 12:18 a.m., resident [redacted] entered resident [redacted] room. At approximately 12:20 a.m., while resident [redacted] was asleep in [redacted] bed, under [redacted] covers, and in a supine position resident [redacted] sat on the edge of resident [redacted] bed. At approximately 12:22 a.m., resident [redacted] placed [redacted] hands on the upper torso / chest area of resident [redacted] and moved [redacted] hand in a back-and-forth motion. Resident [redacted] then placed [redacted] body on top of resident [redacted] body, positioning [redacted] body in a manner that aligned [redacted] chest to resident [redacted] chest and [redacted] pelvic area with resident [redacted] pelvic area. Resident [redacted] then thrusted [redacted] pelvic area against resident [redacted] pelvic area two times. At approximately 12:28 a.m., resident [redacted] sat up in [redacted] bed while resident [redacted] stood approximately 1 foot away from resident [redacted] with [redacted] [redacted] out of [redacted] pants. Resident [redacted] [redacted] from [redacted] bed and maneuvered away from resident [redacted] and walked across [redacted] private room towards a lamp. Resident [redacted] followed resident [redacted] across the room with [redacted] penis in [redacted] left hand. Resident [redacted] turned on the lamp and then escorted resident [redacted] out of [redacted] room.

Plan of Correction ***Accept[redacted] - 06/27/2024)***

· Resident [redacted] was sent to the hospital on [redacted] and was discharged to a different facility. Resident [redacted] will not be returning to Community.

· Resident [redacted] no longer in community. Discharged [redacted]

42b - Abuse (continued)

· Following the incident with Resident [redacted], Community implemented status checks and a 1:1 caregiver for Resident [redacted] was also relocated to a different apartment down the hall and away from Resident [redacted]. Executive Director issued a lease termination notice and [redacted] moved out on [redacted].

· Executive Director/ Designee will retrain all staff on abuse and neglect policy OP-004 Preventing, Detecting, and Reporting Abuse, Neglect, and Exploitation by [redacted]

· Executive Director/ Designee and/or Resident Service Director will audit all incident reports weekly for the next 90 days to ensure proper documentation and reporting per regulation starting [redacted].

Licensee's Proposed Overall Completion Date: *07/15/2024*

Implemented [redacted] - 07/22/2024)

225c - Additional Assessment

3. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident [redacted] most recent assessment and support plan completed on [redacted] assessed the mental health needs of resident [redacted] as "resident has no mental health needs" and a plan to meet this need of "has no mental health needs with an updated service plan to meet resident [redacted] mental health needs on [redacted] of "resident [redacted] often gets agitated, wanting [redacted] to pick [redacted] up has been difficult to redirect 30-day notice issued requested family provide one-on-one care. Resident [redacted] family declined to provide one-on-one care. However, the home's assessment of resident [redacted] supervision needs remained unchanged indicating an assessment of supervision needs of "does not require supervision at the community or outside the community" with a plan to meet this assessed supervision need of "staff will supervise while in the community family will supervise while out of the community". Resident [redacted] assessment and support plan regarding resident [redacted] supervision needs indicated that an allotment of zero additional minutes of supervision would be provided to resident [redacted] that was beyond the standard level of supervision services provided to all residents residing on the secured memory unit unless otherwise specified. On approximately [redacted], resident [redacted] pushed resident [redacted] causing resident [redacted] to cry for approximately 30 minutes while repeatedly stating I am scared.

225c - Additional Assessment (continued)

Resident [redacted] assessment and support plan completed on [redacted], indicated a mental health assessment of resident [redacted] as "resident has no mental health needs and a plan to meet this service need of "has no mental health needs. Resident [redacted] has engaged in multiple incidents of verbal and physical aggression towards staff members and residents to include on approximately [redacted] resident [redacted] became aggressive and agitated, staff attempts at redirection resulted in resident [redacted] becoming more agitated. On approximately [redacted] 9:50 p.m., resident [redacted] became very aggressive and combative with staff. Staff members' attempted redirections were not successful. On approximately [redacted] 10:45 p.m., resident [redacted] became verbally aggressive with staff and began yelling at staff. Staff attempts at redirection were not successful. On approximately [redacted], 6:30 p.m., resident [redacted] invaded the personal space of a staff member screaming at [redacted] let me out. On approximately [redacted] resident [redacted] exhibited dangerous behavior and increased aggression. and required transportation to Cranberry UPMC Passavant Hospital. On approximately [redacted], resident [redacted] became physically aggressive while attempting to enter onto the elevator and struck a personal care giver in the face. On approximately [redacted], resident [redacted] became physically aggressive with staff, kicking and pushing staff members. On approximately [redacted], resident [redacted] became aggressive hitting the elevators with [redacted] fists and attempted to push / pull another resident and became aggressive with staff when they attempted to intervene, pushing a staff member into a wall and screaming who in the hell do you think you are. On approximately [redacted], resident [redacted] became verbally aggressive with staff members and then pushed two female residents, at approximately 11:00 p.m., that same day resident [redacted] became verbally aggressive with staff members and began beating on the elevator doors. On approximately [redacted], resident [redacted] attempted to enlist the assistance of multiple other residents to partake in a planned elopement, upon staff attempting to redirect resident [redacted] became physically aggressive hitting and pushing staff members. On approximately [redacted], resident [redacted] invaded the personal space of resident [redacted], staff redirection attempts were not successful, the incident escalated resulting in resident [redacted] pushing resident [redacted]. On approximately [redacted], resident [redacted] became physically aggressive with resident [redacted] pushing [redacted] into a wall causing resident [redacted] to fall onto the floor. Resident [redacted] cried out "ow" in pain and experienced significant fear as [redacted] crawled on [redacted] hands and knees in an attempt to remove [redacted] from resident [redacted] proximity. However, an updated assessment / plan of service for resident [redacted] mental health needs was not completed until [redacted].

Plan of Correction ***Accept [redacted] 06/26/2024)***

· Resident [redacted] was sent to the hospital on [redacted] and was discharged to a different facility. Resident [redacted] will not be returning to Community.

· Resident Service Director/Designee will complete an audit of all resident service plans/support plans by 7/27/2024 to ensure service plans/support plan document/address the residents mental health needs/behaviors. Any issues found during audit will be addressed immediately.

· Regional Care Director will provide additional training on 2600.225c to Executive Director/Resident Service Director/Designee on or before 7/27/2024 to ensure service plans/support plans document/address mental health needs/behaviors.

· Executive Director/Designee and Resident Service Director will conduct weekly audits beginning 6/21/2024 for the next 90 days to review all new support plans to ensure service plans/support plans have documentation to address mental health/behavior needs.

Licensee's Proposed Overall Completion Date: *07/27/2024*

Implemented [redacted] - 07/22/2024)

227b - Support Plan Content

4. Requirements

2600.

227b - Support Plan Content *(continued)*

227.b. A home may use its own support plan form if it includes the same information as the Department's support plan form.

Description of Violation

On approximately [redacted], at resident [redacted] Power of Attorney's request the home implemented a policy to keep resident [redacted] door locked when [redacted] was sleeping. However, this service was not indicated on resident [redacted] most recent assessment and support plan dated [redacted]

Plan of Correction ***Accept [redacted] - 06/26/2024)***

· Resident Service Director updated Resident [redacted] support plan on [redacted] to include ensuring resident door is locked when resident is in apartment (please note, the citation references Resident [redacted] but we believe that to be in error).
· Resident Service Director will audit all support plans to ensure any family requests have been captured. Audit will be completed on or before 7/27/2024 and any necessary updates will be made immediately.
· Regional Care Director will provide additional training on 2600.227b to Executive Director/Resident Service Director/Designee on or before 7/27/2024 to ensure service plans/support plans document/address appropriate family requests.
· Executive Director/Designee and Resident Service Director will meet weekly starting 6/21/2024 for next 90 days to review all family requests to ensure support plans have proper documentation.

Licensee's Proposed Overall Completion Date: *07/27/2024*

Implemented [redacted] - 07/22/2024)