

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

January 3, 2025

[REDACTED]
THE ARBORS AT ST BARNABAS INC
[REDACTED]
[REDACTED]

RE: THE ARBORS AT ST. BARNABAS
85 CHARITY PLACE
VALENCIA, PA, 16059
LICENSE/COC#: 42309

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/03/2024, 08/12/2024 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: *THE ARBORS AT ST. BARNABAS* License #: *42309* License Expiration: *11/10/2024*
 Address: *85 CHARITY PLACE, VALENCIA, PA 16059*
 County: *BUTLER* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *THE ARBORS AT ST BARNABAS INC*
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *06/04/2010* Issued By: *Adams Township*
 Type: *I-1* Date: *01/09/2020* Issued By: *Adams Township*

Staffing Hours

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

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *08/12/2024*

Inspection Dates and Department Representative

06/03/2024 - On-Site: [REDACTED]
 08/12/2024 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *229* Residents Served: *54*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Second Floor* Capacity: *47* Residents Served: *18*

Hospice
 Current Residents: *0*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *54*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *1*
 Have Mobility Need: *22* Have Physical Disability: *0*

Inspections / Reviews

06/03/2024 Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/05/2024*

Inspections / Reviews *(continued)*

09/11/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2024

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 09/18/2024

10/01/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/15/2024

01/03/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/15/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

15b - Supervisor Plan

1. 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], at approximately 8:00 a.m., an allegation of abuse alleging that staff member A had physically abused resident [REDACTED] was reported to the home. However, staff member A was on duty at the home on multiple dates/times to include [REDACTED], and [REDACTED], from 10:45 p.m., to 7:15 a.m.

On [REDACTED], at approximately 8:00 a.m., an allegation of abuse alleging that staff member B had physically abused resident [REDACTED] was reported to the home. However, staff member B was on duty at the home on multiple dates/times to include [REDACTED] during the 10:30 p.m., to 7:00 a.m., shift.

Plan of Correction

Accept [REDACTED] - 10/01/2024)

Assuming, for the sake of this discussion only and without agreeing to any of the alleged facts, the validity of the deficiencies noted in the Department of Human Service's Statement of Deficiencies Report to The Arbors at St. Barnabas, Valencia for the Survey ending [REDACTED], which alleged deficiencies The Arbors at St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Inc. as to the validity of the deficiencies noted in the report.

- a zoom conference call was held with resident's [REDACTED] on [REDACTED]. It was at that time that an allegation of abuse was made from a fall the resident had on [REDACTED]. No prior communication from [REDACTED] indicated any allegation of abuse. The LPN from our facility had several conversations with the [REDACTED] prior to 5.29.24 concerning resident's status and [REDACTED] made no mention. The [REDACTED] vacated the apartment of resident's belongings on [REDACTED] and still did not give any indication of suspected abuse.
- the two staff members in question were removed from the schedule on [REDACTED] and suspended by the administrator immediately upon the DHS representative's direction.
- education on regulation 2600.15b. (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) will be provided to all staff by the administrator and/or designee. This education will be completed by 10.14.24.
- starting on 10.14.24 the administrator will continue to monitor any and all allegations of suspected abuse reporting and act accordingly with requirements of regulation 2600.15b

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented [REDACTED] - 01/02/2025)

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

The home suspected staff member C of falsifying narcotic log documentations for resident [REDACTED] prescribed [REDACTED]

16c Written Incident Report (continued)

■■■■■ tablet take one tablet by mouth every eight hours for pain only at night. However, the home failed to notify the department.

Plan of Correction

Accept ■■■■ - 10/01/2024)

Assuming, for the sake of this discussion only and without agreeing to any of the alleged facts, the validity of the deficiencies noted in the Department of Human Service's Statement of Deficiencies Report to The Arbors at St. Barnabas, Valencia for the Survey ending June 3, 2024, which alleged deficiencies, The Arbors at St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Inc. as to the validity of the deficiencies noted in the report.

- after investigation, staff member c was terminated on ■■■■ for falsifying narcotic log documentation.
- education on regulation 2600.16c. (the home shall report the incident or condition to the department) will be provided to all staff by the administrator and/or designee. This education will be completed by 10.14.24.
- starting on 10.14.24 audits on all narcotic logs will be completed to ensure accuracy by the administrator and/or designee. The audits will consist of six narcotic logs weekly for one month, bi monthly for one month and monthly thereafter.
- all audits will be reviewed by the administrator and team at the department's quality assurance meeting in February 2025.

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented ■■■■ - 01/02/2025)

42b - Abuse

3. 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 ■■■■ most recent assessment and support plan completed on ■■■■ indicates a personal care need of ambulation as independent and a plan to meet this service need of not applicable. On ■■■■ at approximately 1:30 a.m., staff member B observed that resident ■■■■ had fallen in the hallway immediately outside of the resident's room. Staff member B enlisted the assistance of staff member A to assist with resident ■■■■. Both staff members observed resident ■■■■ to not be at ■■■■ ambulatory baseline presenting with a significantly increased need for assistance while ambulating.

Staff members A and B both hooked their arms under each of the resident's arms and pulled ■■■■ backwards down the hall with ■■■■ feet dragging, from the hallway immediately outside of ■■■■ room and onto the resident's bed. During the escort resident ■■■■ legs were stationery and were dragging across the resident's room's floor. During the escort resident ■■■■ cried out in pain multiple times while grimacing. Upon reaching the bed the resident was allowed to free fall from a standing position onto the bed's mattress. Staff member A indicated that ■■■■ realized this was an improper technique but due to resident ■■■■ being so far off of ■■■■ ambulation baseline and ■■■■ inability to bear weight staff member A believed they had no choice but to transport resident ■■■■ in the manner they did.

At approximately 5:00 a.m., staff member C, a licensed Practical Nurse was requested to assess the resident. While assessing resident ■■■■ ■■■■ was unable to sit up and cried out in pain when attempting to sit up. Staff member C assessed resident ■■■■ pain level to be a 10 on a 1 through 10 pain scale.

On ■■■■ at approximately 7:00 a.m., resident ■■■■ was transported to UPMC Passavant hospital where the video footage of staff members A and B escorting resident ■■■■ was assessed to indicate resident ■■■■ was clearly

42b Abuse (continued)

uncomfortable with the movement. Resident [REDACTED] was subsequently admitted for a fall / [REDACTED] and [REDACTED] compression fracture.

On [REDACTED] staff member A and staff member B were arrested by the Adams Township Police Department for the interactions they had with resident [REDACTED] on [REDACTED]. Staff member A and staff member B were subsequently charged with neglect of a care dependent person failure to provide care.

Plan of Correction

Accepted [REDACTED] - 10/01/2024)

Assuming, for the sake of this discussion only and without agreeing to any of the alleged facts, the validity of the deficiencies noted in the Department of Human Service's Statement of Deficiencies Report to The Arbors at St. Barnabas, Valencia for the Survey ending [REDACTED] which alleged deficiencies The Arbors at St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Inc. as to the validity of the deficiencies noted in the report.

Timeline of events for resident:

[REDACTED] resident had fall, sent to hospital, never returned to the facility. Hospital and [REDACTED] were called several times to get an update. No information leading to suspected abuse was indicated by daughter or hospital. No indication of acute fractures was given.

[REDACTED] gave notification to admission team [REDACTED] would be moving [REDACTED] belongings from the facility. Once again [REDACTED] did not allege any suspected abuse.

[REDACTED] movers onsite

[REDACTED] zoom meeting scheduled for following day on [REDACTED] was cancelled by [REDACTED] the rescheduled zoom meeting was with [REDACTED] and [REDACTED]. Allegation of abuse made during the meeting regarding a fall resident had in our facility on [REDACTED] in which [REDACTED] was sent to the hospital. Family did not share video at that time. Verbal report made immediately to AAA and written report sent to DHS. Investigation into alleged abuse incident initiated.

[REDACTED] written report sent to AAA. Staff in question were interviewed and written statements received by both employees.

[REDACTED] DHS representative onsite, both staff members were removed from schedule and suspended by the administrator. During exit when referenced to the recorded video was mentioned, administrator and nurse having never seen the video requested to see it. A short clip from ring video starting with the resident in living room was shown by the DHS representative. DHS representative stated in his opinion the indicated allegation was not malicious in nature but that staff members needed additional training.

[REDACTED] DHS representative called to discuss final exit with potential violations regarding the [REDACTED] onsite visit. DHS representative informed administrator and nurse that medical records indicated a compression fracture was found on [REDACTED].

· our current staff are being educated on post fall injuries along with resident abuse guidance by the administrator or designee. Education on regulation 42b (a resident may not be neglected, intimidated, physically or verbally abused, mistreated in any way) will also be provided to all current staff by administrator and/or designee. All education will be completed by [REDACTED].

· the administrator reached out to the local ombudsmen on [REDACTED] to request a staff training be held onsite. date of staff training to be determined.

· starting on [REDACTED] audits on immediate treatment post fall will be completed on 0 3 residents weekly for one month, bi weekly for a month and then monthly thereafter. The audit will be conducted by the administrator and/or designee.

· the audits will be reviewed by the administrator and team at the quality assurance meeting in February 2025.

42b Abuse (continued)

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented [REDACTED] - 01/02/2025)

185b - Medication Procedures

4. Requirements

2600.

185.b. At a minimum, the procedures must include:

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] tablet take one tablet by mouth every eight hours for pain only at night. Staff member B administered the medication on [REDACTED], at 5:00 a.m., and indicated this on the narcotic logs [REDACTED] entry. However, the time indicated in the narcotic log entry for the date of [REDACTED], at 5:00 a.m., had been overwritten with a time entry of 12:00 a.m.

Resident [REDACTED] is prescribed [REDACTED] tablet take one tablet by mouth every eight hours for pain only at night. There were [REDACTED] tablets of this medication delivered on [REDACTED]. However, there is no record of the medications administrations in the home's narcotic logbook from [REDACTED] through [REDACTED], the narcotic logs are missing.

Plan of Correction

Accept [REDACTED] - 10/01/2024)

Assuming, for the sake of this discussion only and without agreeing to any of the alleged facts, the validity of the deficiencies noted in the Department of Human Service's Statement of Deficiencies Report to The Arbors at St. Barnabas, Valencia for the Survey ending [REDACTED], which alleged deficiencies The Arbors at St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Inc. as to the validity of the deficiencies noted in the report.

- after investigation, staff member c was terminated on [REDACTED] by the administrator and human resource representative for falsifying narcotic log documentation.
- education on regulation 2600.185.b and the importance of not falsifying documentation will be provided to all staff by the administrator and/or designee. This education will be completed by 10.14.24.
- starting on 10.14.24 audits on all narcotic logs will be completed to ensure accuracy by the administrator and/or designee. The audits will consist of six narcotic logs weekly for one month, bi monthly for one month and monthly thereafter.
- the audits will be reviewed by the administrator and team at the quality assurance meeting in February 2025.

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented [REDACTED] - 01/02/2025)

187b - Date/Time of Medication Admin.

5. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident [REDACTED] is prescribed [REDACTED] tablet take one tablet by mouth every eight hours for pain only at

187b - Date/Time of Medication Admin. (continued)

night. The medication was administered on multiple dates to include to include [REDACTED] at 12:00 p.m., and [REDACTED], at 2:00 a.m. However, the administration of this medication was not indicated on the resident's May 2024, medication administration record.

Plan of Correction**Accept [REDACTED] - 10/01/2024)**

Assuming, for the sake of this discussion only and without agreeing to any of the alleged facts, the validity of the deficiencies noted in the Department of Human Service's Statement of Deficiencies Report to The Arbors at St. Barnabas, Valencia for the Survey ending [REDACTED], which alleged deficiency The Arbors at St. Barnabas does not admit, we offer the following Plan of Correction. Nothing contained in the Plan of Correction shall/should be deemed an admission, either expressed or implied, on the part of The Arbors at St. Barnabas, Inc. as to the validity of the deficiencies noted in the report.

- after investigation, staff member c was terminated on [REDACTED] by the administrator and human resource representative for falsifying narcotic log documentation.
- education on regulation 2600.187.b (the information needs to be recorded at the time of administration) will be provided to all staff by the administrator and/or designee. This education will be completed by 10.14.24.
- starting on 10.14.24 audits on all narcotic logs will be completed to ensure accuracy by the administrator and/or designee. The audits will consist of six narcotic logs weekly for one month, bi-monthly for one month and monthly thereafter.
- the audits will be reviewed by the administrator and team at the quality assurance meeting in February 2025.

Licensee's Proposed Overall Completion Date: 10/14/2024

Implemented [REDACTED] - 01/02/2025)