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

October 28, 2024

ELK HAVEN NURSING HOME ASSOCIATION INC

RE: SILVER CREEK TERRACE
791 JOHNSONBURG ROAD
ST. MARYS, PA, 15857
LICENSE/COC#: 42602

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/02/2024, 08/05/2024 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: *SILVER CREEK TERRACE* **Licen e #**: *42602* **Licen e Expiration**: *06/20/2025*

Address: *791 JOHNSONBURG ROAD, ST. MARYS, PA 15857*

County: *ELK* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ELK HAVEN NURSING HOME ASSOCIATION INC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *07/09/1997* **I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *08/07/2024*

Inspection Dates and Department Representative

08/02/2024 On Site
08/05/2024 Off Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *52*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *52*
Diagnosed with Mental Illness: *4* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *0* **Have Physical Disability**: *1*

Inspections / Reviews

08/02/2024 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/06/2024*

09/18/2024 - POC Submission

Submitted By: **Date Submitted**: *10/02/2024*
Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/09/2024*

Inspections / Reviews *(continued)*

10/28/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/02/2024*

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

The home did not immediately report the suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act:
** On , at approximately 8:15 pm., resident became upset and noncompliant as staff attempted to help assist into her pajamas. Staff person A was asked to try to get resident to comply, resulting in resident scratching staff person A's arm/shoulder area. Staff person A left resident bedroom, standing in the hallway outside of resident bedroom door, as staff overheard staff person A yelling at resident . Staff intervened and entered resident s bedroom and found resident in a panic, stating "Don't let in here, that , a bad and can't let it happen to anyone else" and "That hurt me". Staff attempted to calm resident down and calling resident for comfort.*

** On , at approximately 5:30 pm., resident requested an alternative meal in place of the main course. When staff returned the plate back to staff person A, working the kitchen, Staff person A refused to exchange the meal, stating resident is not getting the alternative meal and "it sucks to be ". When resident told staff person A that had signed up for the alternative meal, staff person A told resident to "shut up, I'm not arguing with you", shut up, if you're so hungry, stop being a cheap and order DoorDash". Resident did not receive the alternative meal.*

On , at approximately 8:30 pm., staff person A went into resident bedroom to assist resident for bed. When care was completed, resident had an accidental bowel movement in his clothing. As staff went to assist resident , multiple staff overheard staff person A screaming "This is your fault, this is the third time having an accident this week". Staff reported that even though staff person A would not stop yelling at resident , resident did not respond back. However, this allegation of abuse was not reported in accordance with the Older Adult Protective Services Act until 7/25/24.

15a - Resident Abuse Report *(continued)*

Plan of Correction ***Accept 09/18/2024)***

n response to the violation on 08/02/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 07/25/2024 by the Administrator to Complete Act 13 reporting forms and provide them to Adult Protective Services.

To enhance the currently compliant operations, on 07/24/2024 the Administrator held an immediate education with staff on abuse and abuse reporting. In-person training session held 8/22/2024 by Adult Protective Services for all staff members. Administrator completed training in abuse and abuse reporting on 8/22/2024, with a completion date of 08/22/2024.

Effective 07/24/2024 the Administrator will perform annual education through adult protective services to maintain ongoing compliance with immediately reporting 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. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous mprovement purposes. This process will be ongoing and added to the annual education for staff.

Licensee's Proposed Overall Completion Date: *08/28/2024*

Implemented - 10/28/2024)

15b - Supervisor Plan

2. 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 the following dates, allegation of staff to resident abuse by staff person A was observed. The home did not immediately develop and implement a plan of super ision or suspend the staff person involved in the al eged incident. Staff person A continued to work unsupervised providing direct care until termination on
** On 7/9/24, at approximately 8:15 pm., resident became upset and noncompliant as staff attempted to help assist into pajamas. Staff person A was asked to try to get resident to comply, resulting in resident scratching staff person A’s arm/shoulder area. Staff person A left resident bedroom, standing in the hallway outside of resident bedroom door, as staff overheard staff person A yelling at resident Staff intervened and entered resident bedroom and found resident in a panic, stating “Don’t let in here, that , a bad and can’t let it happen to anyone else” and “That hurt me”. Staff attempted to calm resident down and calling resident for comfort.*

** On 7/13/24, at approximately 5:30 pm., resident requested an alternative meal in place of the main course. When staff returned the plate back to staff person A, working the kitchen, Staff person A refused to exchange the meal, stating resident is not getting the alternative meal and “it sucks to be . When resident told staff person A that he had signed up for the alternative meal, staff person A told resident to “shut up, I’m not arguing with you”, shut up, if you’re so hungry, stop being a cheap bastard and order DoorDash”. Resident did not receive the alternative meal.*

15b - Supervisor Plan (continued)

** On 7/23/24, at approximately 8:30 pm., staff person A went into resident bedroom to assist resident for bed. When care was completed, residen had an accidental bowel movement in clothing. As staff went to assist resident , multiple staff overheard staff person A screaming "This is your fault, this is the third time having an accident this week". Staff reported that even though staff person A would not stop yelling at resident , resident did not respond back.*

Plan of Correction ***Accept - 09/18/2024)***

n response to the violation on 08/02/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 07/25/2024 by the Administrator to Terminate staff member A.

To enhance the currently compliant operations, on 07/25/2024 the Administrator Educated all staff on abuse and abuse reporting. 8/22/2024 In-person education completed with all staff by adult protective services. Policy and Procedure reviewed and updated to best align with regulatory compliance, with a completion date of 08/22/2024.

Effective 07/25/2024 policy and procedure updated that all staff will be suspended during allegations of abuse until an investigation can be completed. Pending the outcome of the investigation employee may return to work. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous mprovement purposes.

Licensee's Proposed Overall Completion Date: *08/28/2024*

Implemented - 10/28/2024)

16c - Written Incident Report

3. 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 did not report the following incidents to the Department:

** On 3/23/24, at 4:30 pm., staff person A did not administer resident , 1 tab twice daily and , 1 tab once daily.*

** On 7/9/24, at approximately 8:15 pm., resident became upset and noncompliant as staff attempted to help assist into her pajamas. Staff person A was asked to try to get resident to comply, resulting in resident scratching staff person A's arm/shoulder area. Staff person A left resident bedroom, standing in the hallway outside of resident bedroom door, as staff overheard staff person A yelling at resident . Staff intervened and entered resident bedroom and found resident in a panic, stating "Don't let in here, that , a bad and can't let it happen to anyone else" and "That hurt me". Staff attempted to calm resident down and calling resident for comfort.*

16c - Written Incident Report (continued)

** On 7/13/24, at approximately 5:30 pm., resident requested an alternative meal in place of the main course. When staff returned the plate back to staff person A, working the kitchen, Staff person A refused to exchange the meal, stating resident is not getting the alternative meal and "it sucks to be ". When resident told staff person A that had signed up for the alternative meal, staff person A told resident to "shut up, I'm not arguing with you", shut up, if you're so hungry, stop being a cheap and order DoorDash". Resident did not receive the alternative meal.*

On 7/23/24, at approximately 8:30 pm., staff person A went into resident bedroom to assist resident for bed. When care was completed, resident had an accidental bowel movement in clothing. As staff went to assist resident multiple staff overheard staff person A screaming "This is your fault, this is the third time having an accident this week". Staff reported that even though staff person A would not stop yelling at resident , resident did not respond back. The home did not report this incident to the Department until 7/26/24.

Plan of Correction ***Accept - 09/18/2024)***

n response to the violation on 08/02/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on 08/07/2024 by the Administrator to complete the reportable incident forms and send them to the department with a notification of the late reporting.

To enhance the currently compliant operations, on 08/05/2024 the Administrator reviewed all incidents that occurred within the facility for the past year and ensured reportable forms were completed.

Effective 08/05/2024 the Administrator will perform ongoing compliance with reporting an 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, and to follow the guidelines in § 2600.15 (relating to abuse reporting covered by law). Any deficiencies will be corrected immediately, and findings will be documented and reviewed nternally for continuous improvement purposes. The administrator will sign off on all abuse allegations ongoing ensuring proper notification and reporting.

Licensee's Proposed Overall Completion Date: *08/29/2024*

Implemented (- 10/28/2024)

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On , at approximately 5:30 pm., resident requested an alternative meal in place of the main course. When staff returned the plate back to staff person A, working the kitchen, Staff person A refused to exchange the meal, stating resident is not getting the alternative meal and "it sucks to be ". When resident told staff person A that he had signed up for the alternative meal, staff person A told resident to "shut up, I'm not arguing with you", shut up,

42c - Treatment of Residents (continued)

if you're so hungry, stop being a cheap bastard and order DoorDash". Resident did not receive the alternative meal.

On , at approximately 8:30 pm., staff person A went into resident bedroom to assist resident for bed. When care was completed, resident had an accidental bowel movement in clothing. As staff went to assist resident , multiple staff overheard staff person A screaming "This is your fault, this is the third time having an accident this week". Staff reported that even though staff person A would not stop yelling at resident , resident did not respond back.

Plan of Correction ***Accept 09/18/2024)***

n response to the violation on 08/02/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken on by the Administrator to Terminate the employment of staff member A and perform education on abuse and abuse reporting with staff. On 8/22/2024 on-site training was completed by Adult Protective Services.

To enhance the currently compliant operations on 08/05/2024 the Administrator will provide annual in-person abuse education through Adult Protective Services. The administrator will educate residents during the next resident council meeting regarding their rights as a resident and the process if they feel their rights have been violated.

Effective 08/05/2024 the Administrator will perform random resident interviews weekly for one month and then monthly for six months to maintain ongoing compliance with treating residents with dignity and respect. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous mprovement purposes.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented - 10/28/2024)

225c - Additional Assessment

5. 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

The assessment for resident , dated , does not include the resident's history of making allegations when upset over staff's care.

The assessment for resident , dated does not include the resident's need for bowel and bladder management.

225c - Additional Assessment *(continued)*

Plan of Correction ***Accept - 09/18/2024)***

n response to the violation on 08/02/2024 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken:

1. *on 08/02/2024 by the Administrator to Update the resident assessment and support plan for resident to nclude the resident's history of making rape allegations when upset over staff's care.*
2. *on 08/02/2024 by the Administrator to update the resident assessment and support plan for resident to nclude the resident's need for bowel and bladder management.*
3. *on 08/02/2024 by the Administrator to educate the director of wellness of the need to update resident assessments and support plans when changes occur with care.*

To enhance the currently compliant operations, on 08/02/2024 the Director of wellness will Review resident assessments and support plans to ensure information is pertinent to current levels of care. The resident assessment and support plan will be updated per regulatory requirements, with a completion date of 09/30/2024.

Effective 08/02/2024 the Administrator will perform Weekly audits for one month and then monthly audits for six months to maintain ongoing compliance with ensuring each resident has additional assessments, including if the condition of the resident significantly changes prior to the annual assessment. Any deficiencies will be corrected mmediately, and findings will be documented and reviewed internally for continuous improvement purposes.

Licensee's Proposed Overall Completion Date: *09/30/2024*

Implemented - 10/28/2024)