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

February 25, 2025

ELIZABETH SETON CARE CENTER

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

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/18/2024, 09/20/2024, 10/02/2024 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: *ELIZABETH SETON MEMORY CARE CENTER* **License #**: *44577* **License Expiration**: *09/14/2025*

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

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

Administrator

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

Legal Entity

Name: *ELIZABETH SETON CARE CENTER*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *10/02/2024*

Inspection Dates and Department Representative

09/18/2024 - On-Site:
09/20/2024 - Off-Site:
10/02/2024 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *24* **Residents Served**: *12*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Whole Building* **Capacity**: *24* **Residents Served**: *12*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *12*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *12* **Have Physical Disability**: *0*

Inspections / Reviews

09/18/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/03/2024*

Inspections / Reviews *(continued)*

11/13/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *12/30/2024*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *11/20/2024*

12/27/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *12/30/2024*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *12/31/2024*

02/25/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *12/30/2024*
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

On , resident told staff person A that staff person B had been very rough with resident during care. The resident was crying, upset, scared, and stating had never before been handled that roughly. However, this allegation of abuse was not reported immediately in accordance with OPSA.

On 9/13/24, during the overnight shift, resident was sitting in an armchair in the common TV room of the home. Staff person B was sitting on the arm of the chair and used body to lean over resident to keep from getting up out of the chair. Resident began to yell. Staff person A heard resident yelling and went into the common TV room, where witnessed resident breathing heavily, anxious, and stating, "I can't believe this is happening, is holding me here. I need to go." However, this allegation of abuse was not reported immediately in accordance with OPSA.

On two separate occasions between the end of August 2024 and the beginning of September 2024, staff person C witnessed staff person B use legs and arms to keep resident from getting up out of an armchair in the home. Resident was asking staff person B to get off of Resident would then let out a "huff" and pretend to fall asleep until staff person B got off of the resident. Staff person C indicated that resident would be agitated after the incident and difficult to calm down and redirect. However, these allegations of abuse were not reported immediately in accordance with OPSA.

Plan of Correction ***Accept (- 12/27/2024)***

On 9/18/24 Administrator suspended staff person B. See attachment 1A.
On 9/18/24 Administrator posted a memo to all staff reminding them that in accordance with the Older Adult Protective Services Act, it is the responsibility of every staff member to report suspected abuse immediately. See attachment 1B.
On 10/28/24 Administrator compiled Supplemental Staff Training Guide. See Attachment 1C.
On 10/30/24 Administrator began to have each staff member review the Supplemental Training Guide and sign acknowledgement of review. See Attachment 1D
Supplemental Training Guide will be completed by staff persons by 11/30/24.
Monitoring of incidents and events has been added to the daily Med Tech Communications Form. In addition, a Med Tech Daily Communications audit form has been created for daily review by the Administrator or designee to ensure that any allegations of abuse are immediately reported. See attached forms.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented - 02/25/2025)

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).

16c Written Incident Report *(continued)*

Description of Violation

On [redacted], resident [redacted] told staff person A that staff person B had been very rough with the resident [redacted] during care. The resident was crying, upset, scared, and stating [redacted] had never before been handled that roughly. However, the home did not report this incident to the Department.

On [redacted], during the overnight shift, resident [redacted] was sitting in an armchair in the common TV room of the home. Staff person B was sitting on the arm of the chair and used [redacted] body to lean over resident [redacted] to keep [redacted] from getting up out of the chair. Resident [redacted] began to yell. Staff person A heard resident [redacted] yelling and went into the common TV room, where [redacted] witnessed resident [redacted] breathing heavily, anxious, and stating, "I can't believe this is happening, [redacted] is holding me here. I need to go." However, the home did not report this incident to the Department until 9/17/24.

On two separate occasions between the end of August 2024 and the beginning of September 2024, staff person C witnessed staff person B use [redacted] legs and arms to keep resident [redacted] from getting up out of an armchair in the home. Resident [redacted] was asking staff person B to get off of [redacted] Resident [redacted] would then let out a "huff" and pretend to fall asleep until staff person B got off of the resident. Staff person C indicated that resident [redacted] would be agitated after the incident and difficult to calm down and redirect. However, the home did not report these incidents to the Department until 9/17/24.

Plan of Correction ***Accept [redacted] - 12/27/2024)***

Any staff member suspecting abuse will report it within 24 hours to the Department's Personal Care Home Regional Office or the Personal Care Home Complaint Hotline as listed on the Resident's Rights Information Poster which is posted on the bulletin board in the common area of the home. (see attachment 2) The reporting requirement is also included the Supplemental Training Materials in Attachment 1C.
Reportable Incident Training was reviewed with staff at a mandatory meeting on 11/18/24. Reportable Incidents Training materials will be reviewed by each staff member by 11/30/24. Staff will sign training acknowledgement form which will be retained in the education binder. Reportable Incident Training materials are attached.
Reportable incidents will be monitored daily by the administrator or designee by use of the Med Tech Daily Communications sheet. See attached sheet.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented [redacted] - 02/25/2025)

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

On 9/13/24, during the overnight shift, resident [redacted] was sitting in an armchair in the common TV room of the home. Staff person B was sitting on the arm of the chair and used [redacted] body to lean over resident [redacted] to keep [redacted] from getting up out of the chair. Resident [redacted] began to yell. Staff person A heard resident [redacted] yelling and went into the common TV room, where [redacted] witnessed resident [redacted] breathing heavily, anxious, and stating, "I can't believe this is happening, [redacted] is holding me here. I need to go."

42b - Abuse (continued)

On two separate occasions between the end of August 2024 and the beginning of September 2024, staff person C witnessed staff person B use [redacted] legs and arms to keep resident [redacted] from getting up out of an armchair in the home. Resident [redacted] was asking staff person B to get off of [redacted] Resident [redacted] would then let out a "huff" and pretend to fall asleep until staff person B got off of the resident. Staff person C indicated that resident [redacted] would be agitated after the incident and difficult to calm down and redirect.

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

Beginning on 10/30/24 all staff will review the Supplemental Staff Training for Abuse Reporting which includes training on Residents Rights. See attachment 1C.

Staff was reeducated on prohibition of manual restraint at a mandatory meeting on 11/18/24. Reeducation of all staff will be completed by 11/30/24. Reeducation materials are attached.

Administrator or designee will interview 2 residents per week for 1 month beginning on 11/20/24 and monthly thereafter to ensure residents are not mistreated or restrained. Resident Abuse Interview Questionnaire form will be used to interview residents and will be reviewed at the next quality management meeting. Interview form is attached.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented [redacted] - 02/25/2025)

42c - Treatment of Residents

4. Requirements

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

Description of Violation

On [redacted] at approximately 6:30 a.m., during shift change while multiple staff persons and resident [redacted] were seated at a table, staff person B stated [redacted] "H. A. T. E. [redacted] and pointed to resident [redacted]

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

Beginning on 10/30/24 all staff will review the Supplemental Staff Training for Abuse Reporting which includes training on Residents Rights. See attachment 1C.

At the mandatory meeting on 11/18/24 staff was reeducated on the requirement that all residents shall be treated with dignity and respect. The attached training document will be reviewed by all staff by 11/30/24.

Administrator or designee will interview 2 residents per week for 1 month beginning on 11/20/24 and monthly thereafter to ensure residents are treated with dignity and respect. Resident Abuse Interview Questionnaire form will be used to interview residents and will be reviewed at the next quality management meeting. Interview form is attached.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented [redacted] - 02/25/2025)

42p - Restraints

5. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

On [redacted], during the overnight shift, resident [redacted] was sitting in an armchair in the common TV room of the home. Staff person B was sitting on the arm of the chair and used [redacted] body to lean over resident [redacted] to keep [redacted] from getting up out of the chair. Resident [redacted] began to yell. Staff person A heard resident [redacted] yelling and went into the common TV room, where [redacted] witnessed resident [redacted] breathing heavily, anxious, and stating, "I can't believe this is happening, [redacted] is holding me here. I need to go."

On two separate occasions between the end of August 2024 and the beginning of September 2024, staff person C witnessed staff person B use [redacted] legs and arms to keep resident [redacted] from getting up out of an armchair in the home. Resident [redacted] was asking staff person B to get off of [redacted] Resident [redacted] would then let out a "huff" and pretend to fall asleep until staff person B got off of the resident. Staff person C indicated that resident [redacted] would be agitated after the incident and difficult to calm down and redirect.

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

Beginning on 10/30/24 all staff will review the Supplemental Staff Training for Abuse Reporting which includes training on Residents Rights 42p, protecting resident's rights to liberty and dignified treatment. See attachment 1C.

On 11/18/24 staff was reeducated regarding what constitutes manual restraint and the prohibition to any manual restraint. Training materials will be reviewed by all staff and completed by 11/30/24. See attached training materials.

Administrator or designee will interview 2 residents per week for 1 month beginning on 11/20/24 and monthly thereafter regarding care by staff to ensure residents are not mistreated or restrained. Resident Abuse Interview Questionnaire form will be used to interview residents and will be reviewed at the next quality management meeting. Interview form is attached.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented ([redacted] - 02/25/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is ordered a Hoyer lift for all transfers beginning [redacted]. However, multiple staff in the home indicated that they are not using the Hoyer each time to transfer the resident.

Plan of Correction ***Accept ([redacted] - 12/27/2024)***

On 9/18/24 Administrator posted a reminder of all resident lift orders for staff and sent group text to all staff enforcing the requirement to follow all doctors' orders for residents. The list of resident lift requirements will be updated by the administrator as needed. See attachment 3

187d - Follow Prescriber's Orders (continued)

Administrator or designee will observe 1 resident transfer for all residents ordered a Hoyer lift weekly for 1 month and then monthly for 3 months. The attached form will be used to document observations and will be reviewed at the next quality management meeting.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented - 02/25/2025)

202 - Prohibitions

7. Requirements

2600.
202. The following procedures are prohibited:

Description of Violation

On during the overnight shift, resident was sitting in an armchair in the common TV room of the home. Staff person B was sitting on the arm of the chair and used body to lean over resident to keep from getting up out of the chair. Resident began to yell. Staff person A heard resident yelling and went into the common TV room, where witnessed resident breathing heavily, anxious, and stating, "I can't believe this is happening, is holding me here. I need to go."

On two separate occasions between the end of August 2024 and the beginning of September 2024, staff person C witnessed staff person B use legs and arms to keep resident from getting up out of an armchair in the home. Resident was asking staff person B to get off of Resident would then let out a "huff" and pretend to fall asleep until staff person B got off of the resident. Staff person C indicated that resident would be agitated after the incident and difficult to calm down and redirect.

Plan of Correction ***Accept (- 12/27/2024)***

On 10/30/24 the Administrator began staff review of the Supplemental Staff Training (see attachment 1C) which includes section Abuse Orientation Training that includes prohibition of manual restraint of residents.

On 11/18/24 staff was reeducated regarding what constitutes manual restraint and the prohibition to any manual restraint. Training materials will be reviewed by all staff and completed by 11/30/24. See attached training materials.

Administrator or designee will interview 2 residents per week for 1 month beginning on 11/20/24 and monthly thereafter regarding care by staff to ensure residents are not mistreated or restrained. Resident Abuse Interview Questionnaire form will be used to interview residents and will be reviewed at the next quality management meeting. Interview form is attached.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented (SQ - 02/25/2025)

234d - Support Plan Revision

8. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

234d - Support Plan Revision *(continued)*

Description of Violation

A support plan for resident [redacted] was completed on [redacted]; however, resident [redacted] was ordered a Hoyer lift for all transfers beginning [redacted] and the support plan was not updated to include this need. In addition, on [redacted], resident [redacted] was diagnosed with [redacted] on the [redacted] and ordered to cleanse with soap and water daily, pay dry and apply collagen moistened with normal saline to wound bed and cover with dry dressing. However, resident [redacted]s support plan was not updated to include this need to include the responsible party and frequency of care.

Plan of Correction ***Accept [redacted] - 12/27/2024)***

On 9/24/24, in response to our annual inspection, a Resident RASP Audit form was developed to be used by the Administrator/ARCD for auditing each resident file to ensure all changes are in the resident's RASP. Unfortunately, all charts had not been audited by the time of this abuse allegation. The audit form is actively being used by the Administrator at this time. See attachment 4.

Notification of incomplete RASP for resident [redacted] was received AFTER resident [redacted] was deceased, therefore, the RASP was not updated.

RASPs are audited quarterly and annually by Administrator or Assistant Resident Care Director. As a reeducation step, Administrator and ARCD reviewed the RASP audit document on 11/18/24. RASP Audit document attached.

Licensee's Proposed Overall Completion Date: *11/20/2024*

Implemented ([redacted] - 02/25/2025)