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

May 9, 2025

[redacted], PRESIDENT
SENECA MANOR, LLC
[redacted]

RE: SENECA MANOR
5340 SALTSBURG ROAD
VERONA, PA, 15147
LICENSE/COC#: 45549

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/11/2025, 02/12/2025 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: *SENECA MANOR* **License #**: *45549* **License Expiration**: *04/01/2025*

Address: *5340 SALTSBURG ROAD, VERONA, PA 15147*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *SENECA MANOR, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *04/14/2010* **Issued By**: *Municipality of Penn Hills*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *107* **Waking Staff**: *80*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/12/2025*

Inspection Dates and Department Representative

02/11/2025 - On-Site: [redacted]

02/12/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *73*

Special Care Unit

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

Hospice

Current Residents: *11*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *34* **Have Physical Disability**: *0*

Inspections / Reviews

02/11/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/08/2025*

03/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/09/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/16/2025*

Inspections / Reviews *(continued)*

03/17/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *03/25/2025*

05/09/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *05/09/2025*

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

17 Record confidentiality

1. Requirements

2800.

17. Confidentiality of Records - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 2/12/25, at 1:30 p.m., there were multiple resident records and narcotic sheets that were unlocked, unattended, and accessible in the first-floor nurse's station of the home.

Plan of Correction ***Accept ([redacted] - 03/11/2025)***

At the time of discovery, the first-floor nurses station was immediately locked.
All other nurses' stations were checked at that time by the Administrator in the home to ensure records were being stored correctly.
All staff including vendors/agency will be educated on the home policy of storing resident records and closing and locking the nursing station door when unattended. Education to be completed by March 31,2025.
The Director of Resident Care/designee will audit to ensure that nursing station doors are properly locked and confidential records are stored correctly per 2800.17 regulations. Audits will be conducted on two units twice weekly for four weeks, then weekly for four weeks until 100% compliance is reached.

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented ([redacted] - 05/09/2025)

51 Criminal background checks

2. Requirements

2800.

51. Criminal background checks
    a. Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).
    b. The hiring policies shall be in accordance with the Department of Aging's Older Adult Protective Services Act policy as posted on the Department of Aging's web site.

Description of Violation

Staff person A, hired [redacted], does not have a criminal history background check completed.

Staff person B, hired [redacted] does not have a criminal history background check completed.

Plan of Correction ***Accept ([redacted] - 03/17/2025)***

Criminal Background Checks
Staff Person A & B
Criminal background checks for staff A&B were received on 2/14/25.
Human Resources has been educated on the home background check policy that all new employees must have a criminal background check completed prior to employment.
The facility has developed a checklist to ensure all required documents are completed before the first day of work in the facility.
The Administrator/designee will audit all new hires for completion of required documentation prior to initiating work at the facility. Audits will continue indefinitely.

51 Criminal background checks *(continued)*

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented (- 05/09/2025)

54a Direct care staff quals

3. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person B, hied does not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept (- 03/17/2025)***

2800.54a GED
Staff person B
Staff person B's diploma was received on 2/13/25.
Human Resources has been educated on the requirement that all new direct staff persons must have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry prior to employment per 2800.54(a).
The facility has developed a checklist to ensure all required documents are completed before the first day of work in the facility.
The Administrator/designee will audit all new hires for completion of required documentation prior to initiating work at the facility. Audits will continue indefinitely.

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented (- 05/09/2025)

65a Fire Safety-1st day

4. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:
1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person C, whose first day of work was did not receive orientation on any of the required topics in accordance with 2800.65a.

65a Fire Safety-1st day *(continued)*

Plan of Correction ***Accept (- 03/17/2025)***

2800.65
Staff person C will complete education in general fire safety and emergency preparedness.
The educations for staff person C on fire safety and emergency preparedness were completed on 2/22/25.
An audit will be completed to ensure all staff have documentation of orientation in general fire safety and emergency preparedness per requirements at 2800.65.a.
Human Resources has been educated on the requirement that all new hires must have orientation in general fire safety and emergency preparedness per 2800.65.a.
The facility has developed a checklist to ensure all required documents are completed before the first day of work in the facility.
Prior to the first workday, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness.
The Administrator/designee will audit all new hires for completion of required documentation prior to initiating work at the facility. Audits will continue indefinitely.

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented (- 05/09/2025)

69 Dementia training

5. Requirements

2800.
69. Additional Dementia-Specific Training - Administrative staff, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall receive at least 4 hours of dementia-specific training within 30 days of hire and at least 2 hours of dementia-specific training annually thereafter in addition to the training requirements of this chapter.

Description of Violation

Staff person C, hired , received only 2 hours of dementia-specific training within 30 days of hire.

Plan of Correction ***Accept (- 03/17/2025)***

2800.69
Staff person C will complete the remaining required Dementia specific training to meet the requirement at 2800.69.
This training for staff person C was completed on 2/22/25.
An audit will be completed to ensure all staff have documentation of dementia specific training as required at 2800.69
Human Resources has been educated on the requirement that all new hires must have four hours of dementia specific training within 30 days of hire and two hours of training annually thereafter.
The facility has developed a checklist to ensure all required training is completed within 30 days of hire.
The Administrator/designee will audit all new hires for completion of required trainings within 30 days of hire. Audits will continue indefinitely.

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented (- 05/09/2025)

141a Medical evaluation

6. Requirements

141a Medical evaluation *(continued)*

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
6. Immunization history.
11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

The medical evaluation for resident #2, dated [redacted], does not include an immunization history or an indication that a tuberculin skin test has been administered with negative results within 2 years or a chest x-ray has been completed.

The following medical evaluations do not include an indication that a tuberculin skin test has been administered with negative results within 2 years or a chest x-ray has been completed:
- Resident #1, dated [redacted]
- Resident #3, dated [redacted]
- Resident #4, dated [redacted]

Plan of Correction ***Accept ([redacted] - 03/11/2025)***

2800.141.a.
Resident R#2 Immunization history obtained via PIERS system. TB test to be repeated per MD. Immunization history and TB test results will be added as an addendum to the ADME and signed by MD.
Resident #1, #3, #4 TB testing dates have been located and will be added to ADME form as an addendum and signed by MD
A whole house audit will be completed of all residents for completion of immunization history and valid tuberculin skin test or chest x-ray completion.
The Director of Resident Care has been educated by the Administrator on the requirements at 2800.141.a. relating to completion of the immunization history, and tuberculin skin testing/x-rays.
The Director of Resident Care will audit all new admissions for completion of immunization history and completion of tuberculosis testing or documentation of a negative chest x-ray. Audits will be completed on a weekly basis x eight weeks.

Licensee's Proposed Overall Completion Date: *05/02/2025*

Implemented ([redacted] - 05/09/2025)

141b1 Annual medical evaluation

7. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

The most recent medical evaluation for resident #2 was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 03/11/2025)***

2800.141.b.

141b1 Annual medical evaluation (continued)

Resident R#2 Has a physician appointment scheduled for [redacted]
The Director of Resident Care/designee will audit all charts to determine if any other residents require an annual physician evaluation.
The Director of Resident Care was educated by the Administrator on the requirements found at 2800.141.b.
The Director of Resident Care/designee will audit monthly x 3 months for all residents due for annual medical evaluation to ensure timely completion.

Licensee's Proposed Overall Completion Date: *06/10/2025*

Implemented ([redacted] - 05/09/2025)

183e Storing Medications

8. Requirements

2800.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 2/12/24, resident #1's 650mg acetaminophen suppository was on the medication cart; however, the medication expired on 1/14/25, according to the medication label.

On 2/12/24, resident #8's Ondansetron ODT 4mg was on the medication cart; however, the medication expired on 1/4/25, according to the medication label.

Plan of Correction ***Accept ([redacted] - 03/11/2025)***

2800.183.e.
Resident R#1 and Resident #8 medications were disposed of at the time of discovery.
All medication carts were audited for expired medications at the time of survey.
All Licensed Nurses and medication Technicians will be educated on the facility medications storage policy and disposing of expired medications. Education to be completed by March 31, 2025.
The Director of Resident Care/designee will audit two medication carts weekly x4 and then once monthly x2 for expired medications.

Licensee's Proposed Overall Completion Date: *06/10/2025*

Implemented ([redacted] - 05/09/2025)

184a Resident meds labeled

9. Requirements

2800.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
1. The resident's name.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

184a Resident meds labeled *(continued)*

Description of Violation

The pharmacy label for resident #6's Lantus Solostar Insulin does not include the resident's name, the date the prescription was issued, the prescribed dosage and instructions for administration, and the name and title of the prescriber.

Plan of Correction ***Accept (- 03/17/2025)***

184.a.
Resident #6 Lantus was disposed of at the time of survey, and new one was obtained.
All insulins in all medication carts were checked for proper pharmacy labeling at the time of inspection.
All Licensed Nurses and medication Technicians will be educated on the facility insulin labeling requirements.
Education to be completed by March 31, 2025.
The Director of Resident Care/designee will audit two medication carts weekly x4 and then once monthly x2 for properly labeled insulins.
The Director of Resident Care or Designee will audit all med carts at least monthly going forward to ensure proper labeling.

Licensee's Proposed Overall Completion Date: *06/10/2025*

Implemented (- 05/09/2025)

224a5 Written initial assessment

10. Requirements

2800.
224.a.5. The written initial assessment must, at a minimum include the following:
vii. The individual's ability to safely operate key-locking devices.

Description of Violation

Resident #3's assessment dated, does not include the individual's ability to safely operate key-locking device.
Resident #4's assessment dated, does not include the individual's ability to safely operate key-locking device.
Resident#6's assessment dated, , does not include the individual's ability to safely operate key-locking device.

Plan of Correction ***Accept (- 03/11/2025)***

224a5
Resident R#1, #3, #4, #5, #6, #7 ASP assessments have been completed which includes the key locking device.
The facility will audit and complete all missing key locking assessments by May 15, 2025.
The Director of Resident Care and Resident Support Coordinator have been educated on the requirements found at 2800.224.a.5 by the Administrator.
The Director of Resident Care/designee will audit all ASP Forms for completion of locking assessment monthly for three months.

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented (- 05/09/2025)

225b Assessment content

11. Requirements

2800.

225b Assessment content *(continued)*

225.b. The assessment must, at a minimum include the following:

7. The resident's ability to safely operate key-locking devices.

Description of Violation

Resident #1's assessment, dated [redacted] does not include the individual's ability to safely use key-locking device.
Resident #5's assessment, dated [redacted], does not include the individual's ability to safely use key-locking device.
Resident #7's assessment dated [redacted] does not include the individual's ability to safely use key-locking device.

Plan of Correction ***Accept ([redacted] - 03/11/2025)***

224a5
Resident R#1, #3, #4, #5, #6, #7 ASP assessments have been completed which includes the key locking device.
The facility will audit and complete all missing key locking assessments by May 15, 2025.
The Director of Resident Care and Resident Support Coordinator have been educated on the requirements found at 2800.224.a.5 by the Administrator.
The Director of Resident Care/designee will audit all ASP Forms for completion of locking assessment monthly for three months.

Licensee's Proposed Overall Completion Date: *05/15/2025*

Implemented ([redacted] - 05/09/2025)

251c Standardized forms

12. Requirements

2800.
251.c. The residence shall use standardized forms to record information in the resident's record.

Description of Violation

The home did not use the Department's assessment and support plan (ASP) form, and the ASPs of the following residents do not have all of the elements included on the Department's form:
- Resident #1, dated [redacted]
- Resident #3, dated [redacted],
- Resident #4, dated [redacted]
- Resident #5, dated [redacted]
- Resident #6, dated [redacted]
- Resident #7, dated [redacted]

Plan of Correction ***Accept ([redacted] - 03/17/2025)***

224a5
Resident R#1, #3, #4, #5, #6, #7 ASP assessments have been completed which includes the key locking device.
The facility will audit and complete all missing key locking assessments by May 15, 2025.
The Director of Resident Care and Resident Support Coordinator have been educated on the requirements found at 2800.224.a.5 by the Administrator.
The Director of Resident Care/designee will audit all ASP Forms for completion of locking assessment monthly for three months.
Going forward the home will use the Department's assessment and support plan form (ASP).

Licensee's Proposed Overall Completion Date: *05/15/2025*

251c Standardized forms *(continued)*

Implemented (- 05/09/2025)