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

August 8, 2025

[redacted]
SOUTHWEST BEHAVIORAL CARE INC
[redacted]

RE: BARCLAY PLACE
320 WEST PITTSBURGH STREET
GREENSBURG, PA, 15601
LICENSE/COC#: 45387

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/02/2025 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: *BARCLAY PLACE* **License #**: *45387* **License Expiration**: *08/03/2025*

Address: *320 WEST PITTSBURGH STREET, GREENSBURG, PA 15601*

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

Administrator

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

Legal Entity

Name: *SOUTHWEST BEHAVIORAL CARE INC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *R-4* **Date**: *04/20/2022* **Issued By**: *City of Greensburg*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *12* **Waking Staff**: *9*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *06/02/2025*

Inspection Dates and Department Representative

06/02/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *14* **Residents Served**: *12*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *8*

Diagnosed with Mental Illness: *12* **Diagnosed with Intellectual Disability**: *0*

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

Inspections / Reviews

06/02/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/05/2025*

07/10/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/08/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/15/2025*

Inspections / Reviews *(continued)*

07/28/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/08/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/11/2025*

08/08/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/08/2025*

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

15c - Supervision

1. Requirements

2600.
15.c. The home shall immediately submit to the Department's personal care home regional office a plan of supervision or notice of suspension of the affected staff person.

Description of Violation

On [redacted] at approximately 8:30 am, resident [redacted] was using the second-floor staff bathroom when direct care staff member A approached the resident at the door. When the resident opened the door staff member A began yelling at the resident while within 12 inches of [redacted] face telling [redacted] that [redacted] was not allowed to use the staff restroom. The resident closed the door and indicated to the staff member that [redacted] had permission from the home's administrative staff to use the restroom. The staff member and resident began yelling at each other through the door until the resident opened the door. At that time staff member A reached out to grab the door behind the resident and forcefully pulled the door closed moving the resident out of the doorway of the bathroom then verbally directed the resident to [redacted] room. At 9:30 a.m. staff observed resident [redacted] actively crying in [redacted] room and told staff [redacted] was now fearful of staff member A. The home was made aware on [redacted] at 9:45 a.m.; however, staff member A continued working in the home unsupervised and had direct access to the resident until [redacted] at 4:00 p.m.

Plan of Correction ***Accept [redacted] - 07/22/2025)***

Corporate attorney made Barclay managers aware that staff must be immediately suspended when any abuse/neglect allegations arise.
Barclay's director called [redacted] on 5/28/25 4:32pm to notify [redacted] that [redacted] is being placed on unpaid administrative leave pending the investigation of an incident [redacted] was involved in.
Employee [redacted] was notified via mail of [redacted] suspension on [redacted].

To correct this citation moving forward Barclay mangers will adhere to this protocol to suspend staff immediately upon report of possible abuse/neglect.
Staff meeting for July is scheduled for 7/17/25. The agenda for this meeting will include education for staff on this regulation. Education or mock scenarios on incident reporting will take place at each monthly staff meeting for the reminder of the 2025 year.

Licensee's Proposed Overall Completion Date: *07/11/2025*

Implemented [redacted] - 08/08/2025)

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

On [redacted] at approximately 8:30 am, resident [redacted] was using the second-floor staff bathroom when direct care staff member A approached the resident at the door. When the resident opened the door staff member A began yelling at the resident while within 12 inches of [redacted] face telling [redacted] that [redacted] was not allowed to use the staff restroom. The resident closed the door and indicated to the staff member that [redacted] had permission from the home's administrative staff to use the restroom. The staff member and resident began yelling at each other through the door until the

16c Written Incident Report (continued)

resident opened the door. At that time staff member A reached out to grab the door behind the resident and forcefully pulled the door closed moving the resident out of the doorway of the bathroom then verbally directed the resident to [redacted] room. At 9:30 a.m. staff observed resident [redacted] actively crying in [redacted] room and told staff [redacted] was now fearful of staff member A. The home did not report the incident to the Department until [redacted].

Plan of Correction ***Accept [redacted] - 07/28/2025)***

Barclay submitted the ACT 13 Mandatory Abuse Report to the Agency Area on Aging within 24 hours but failed to notify Department of Human Services.
Please see attached form.

During staff meetings, Barclay managers have reviewed and will continue to review with staff what to do when an incident occurs.
Staff will make Team Lead and the Director aware of any instances of abuse/neglect and Team Lead or Director will then follow appropriate procedures.
Director and/or Team Lead will contact [redacted] for residents [redacted] and younger.
Director and/or Team Lead will contact [redacted] for residents [redacted] and older.

Barclay managers have relayed information on incident reporting and completed mock scenarios via staff meeting on [redacted] Staff meeting agenda is attached. Barclay managers also relayed information via email on what number to call and report allegations or suspected abuse on [redacted]. Email is attached. Barclay managers will continue reviewing incident reporting at each monthly staff meeting for the remainder of the 2025 year.

Licensee's Proposed Overall Completion Date: *07/11/2025*

Implemented [redacted] - 08/08/2025)

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 [redacted] at approximately 8:30 am, resident [redacted] was using the second floor staff bathroom when direct care staff member A approached the resident at the door. When the resident opened the door staff member A began yelling at the resident while within 12 inches of [redacted] face telling [redacted] that [redacted] was not allowed to use the staff restroom. The resident closed the door and indicated to the staff member that [redacted] had permission from the home's administrative staff to use the restroom. The staff member and resident began yelling at each other through the door until the resident opened the door. At that time staff member A reached out to grab the door behind the resident and forcefully pulled the door closed moving the resident out of the doorway of the bathroom then verbally directed the resident to [redacted] room. At 9:30 a.m. staff observed resident [redacted] actively crying in [redacted] room and told staff [redacted] was now fearful of staff member A.

42b - Abuse *(continued)*

Plan of Correction ***Accept [redacted] - 07/22/2025)***

As a result of the investigation, SBC has concluded that terminating the identified employee is the best course of action. Please see the attached termination form. The targeted employee was terminated via certified mail on June 26, 2025.

Barclay managers will conduct regular interviews in private with residents to ask about their treatment in the home monthly for the remainder of the 2025 year and keep them informed of their rights. Staff will be retrained in Crisis Prevention and Intervention this fiscal year.

Proposed Overall Completion Date: 07/11/2025

Documentation of the resident interviews shall be kept.

By 8/10/25: All staff persons will be retrained on resident abuse reporting and prevention. Documentation of the retraining shall be kept.

Licensee's Proposed Overall Completion Date: *07/11/2025*

Implemented [redacted] 08/08/2025)