Department of Human Services
Bureau of Human Service Licensing

February 3, 2022

[redacted]
UPMC SENIOR COMMUNITIES INC
896 WEATHERWOOD LANE
GREENSBURG, PA, 15601

RE: WEATHERWOOD MANOR
896 WEATHERWOOD LANE
GREENSBURG, PA, 15601
LICENSE/COC#: 44470

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/03/2021, 12/22/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Janine Wenzig

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

January 24, 2022

[redacted]
UPMC SENIOR COMMUNITIES INC
896 WEATHERWOOD LANE
GREENSBURG, PA, 15601

RE: WEATHERWOOD MANOR
896 WEATHERWOOD LANE
GREENSBURG, PA, 15601
LICENSE/COC#: 44470

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 12/03/2021, 12/22/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Janine Wenzig

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *WEATHERWOOD MANOR* **License #**: *44470* **License Expiration**: *02/25/2023*

Address: *896 WEATHERWOOD LANE, GREENSBURG, PA 15601*

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

Administrator

Name: **Phone**: *7248532084* **Email**:

Legal Entity

Name: *UPMC SENIOR COMMUNITIES INC*

Address: *896 WEATHERWOOD LANE, GREENSBURG, PA, 15601*

Phone: *7248532084* **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *03/26/2013* **Issued By**: *Hempfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *12/03/2021*

Inspection Dates and Department Representative

12/03/2021 - On-Site:

12/22/2021 - Off-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *53*

Special Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

12/03/2021 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/20/2022*

Inspections / Reviews *(continued)*

01/24/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/28/2022*

02/03/2022 - Document Submission

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

15b Resident abuse-superv plan

1. Requirements

2800.
15.b. If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 11/23/2021, at approximately 1:00 p.m., the home's administrator was notified by the Protective Services of an investigation of an allegation of abuse against staff persons A and B, regarding resident #1. The home did not develop and implement a plan of supervision or suspend the the staff persons involved in the alleged incident until 12/2/2021.

Plan of Correction ***Accept***

The home disputes the accuracy of the Description of Violation. The administrator took the necessary steps to notify BHSL regarding this incident. Following is a list of events that occurred:
11/22/2021 - Resident testing for COVID was completed. Resident typically very cooperative and pleasant. The resident was going through a medication change and exhibiting behavior changes, On [redacted]/2021, it was noted that the resident is [redacted]/2021. Resident refused the test when initiated by one nurse. Resident re-approached by another nurse with whom [redacted] has a good rapport. This nurse asked if [redacted] could hold [redacted] hands for reassurance during the test. Resident agreed and the nasopharyngeal swab required for COVID testing was completed.
11/23/2021 - Protective service caseworker entered the building and went directly to the resident's room without introduction to the residence's staff. After meeting the resident, reviewing the record and meeting with some staff, the caseworker spoke with the administrator. The caseworker did not explain the nature of the visit. However, prior to leaving, the caseworker requested some documents be emailed to [redacted] attention which included the resident's: face sheet, diagnosis list, medication list, and most recent nurses notes. The caseworker also stated "there are no red flags and nothing to be concerned about with this matter. This matter should not have made it past our intake worker." Later that evening, the administrator received an email message from the caseworker that was read on 11/24/2021 as a follow up and re-stating the requested documentation and referenced the visit as an "investigation of abuse."
11/24/2021 - Learning that the visit on 11/23/2021 was referred to as an "investigation of abuse", the administrator was alarmed and reached out to BHSL Southwestern Office to clarify what steps were needed due to the protective services worker visiting the residence, communicating that there were no "red flags" and/or concerns and then in a follow up email stated this was an investigation of abuse. The director was unavailable, so [redacted] spoke with a supervisor [redacted]. The administrator was directed to submit a Reportable Incident, but no need to do an Act 13 report.
12/2/2021 - A representative [redacted] from BHSL contacted the administrator requesting a plan of supervision for the two nurses who completed the testing. The report was submitted to BHSL stating one nurse is currently [redacted] and the second nurse would continue to work with the administrator providing direct supervision with any direct resident contact.
12/3/2021 - DHS inspector arrived at the building to investigate. Prior to departing, the inspector stated that a plan of supervision was not required.
Our plan of correction: The Administrator, and Director of Resident Care will be educated by the Regional Administrator regarding strategies to promptly identify an investigation of abuse. The Administrator and Director of Resident Care will also be re-educated on the requirement of a plan of supervision when an allegation of abuse has been identified. This education will be completed and documented by
February 15, 2022.

15b Resident abuse-superv plan *(continued)*

Document Submission ***Implemented***

Per the plan of correction, the education regarding regulation 2800.15 completed.

42b Abuse/Neglect

1. Requirements

2800.
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 /2021, at approximately a.m., resident #1 was sleeping in bed. Staff person A entered the resident's room to administer a nasopharyngeal test for COVID-19. The resident became alarmed, told the staff person to let sleep and pulled the blanket over head. The staff person continued to try to administer the test and the resident swung arms at the staff person. Staff person A again continued to administer the test with the assistance of staff person B. Staff person B placed hands onto the resident's upper arms to prevent the resident from moving as staff person A placed the swab up the resident's nose and deep into the resident's nasal cavity. Resident #1 was struggling to move but was unable to move arms and kicked at the staff persons. The resident was afraid and anguished and yelled The staff persons finished administering the test and left the room. After this, the resident found that nose was bleeding. left room to seek help for the nose bleed.

Plan of Correction ***Accept***

Routine COVID testing of our residents is in compliance with the requirements established by the PA Department of Health and the Department of Human Services. The swab is a nasopharyngeal technique that involves inserting a cotton swab deep into the nasal passage. A common side effect noted with the testing technique is a nosebleed.
On the morning of /2021, the nurse approached the resident to have COVID testing completed. The resident refused the testing. Due to the refusal, the nurse asked the Director of Resident Care (DRC) to assist with the resident. The DRC has a positive relationship with the resident and re-approached and reassured that this is the same testing that was done in the past and asked if can hold hands for reassurance during the swabbing. Resident agreed and the nasopharyngeal swab required for COVID testing was completed. At no time during the interaction was this testing event believed to have met the definition of abuse.
Our plan of correction is, when possible, to administer an anterior nares swab for COVID testing to replace the nasopharyngeal technique. This is a less invasive swab that does not require going as deep into the nasal passages. The accessibility of this test is based on available testing supplies. If the resident continues to refuse, the nurse will not administer the swabbing and re-approach the resident again and the staff will offer reassurance and comfort such as holding the resident's hand. Should the resident continue to refuse, the swabbing will not be completed, and the resident will be re-educated about the testing needs and process.
We will educate employees who have been identified as testers for this facility. Education will include content pertaining to the different types of testing swabs and testing strategies to use to facilitate compliance when testing can cause discomfort. This education will be completed by February 15, 2022.

Document Submission ***Implemented***

Per the plan of correction, the education on the requirements of 2800.42.b. as it relates to COVID testing of residents was completed.