



**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
11 Stanwix Street  
Room 230  
Pittsburgh, Pennsylvania 15222**

**ADULT RESIDENTIAL LICENSING**

Phone: (412) 565-5616/5614  
Toll Free: 1-888-322-3664  
Fax: (412) 565-5633/565-2840  
[www.dpw.state.pa.us](http://www.dpw.state.pa.us)

Mailing Date: **AUG 8 2011**

Ms. Loriann Putzier, Executive Vice President  
Tithonus Mt. Lebanon, LP  
6600 Brooktree Court, Suite 1000  
Wexford, Pennsylvania 15090

RE: The Pines of Mt. Lebanon  
1537 Washington Road  
Pittsburgh, Pennsylvania 15228

Dear Ms. Putzier:

As a result of the Department of Public Welfare's licensing inspection on May 2, 2011 of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.



All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jill Pezzino".

Jill Pezzino  
Regional Licensing Administrator

Enclosure(s)



NAME AND ADDRESS OF PERSONAL CARE HOME THE PINES OF MT LEBANON, 1537 WASHINGTON ROAD PITTSBURGH, PA 15228		CURRENT LICENSE NUMBER 433610	
INSPECTION DATES (Include all dates of the inspection) 05/02/2011		REGIONAL REPRESENTATIVE N. Mandock, T. Newman	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan)			
SIGNATURE OF LEGAL ENTITY 	DATE 7/29/11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION 	DATE 8-5-11

REGULATION 55 Pa.Code §2600	VIOLATION	DATE COMPLIANCE VERIFIED BY	PLAN OF CORRECTION	DATE COMPLIANCE VERIFIED BY
15a 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.	On 04/27/11, at approximately 2:00a.m., staff person A overheard staff person B yelling at resident #1 to lay back down and go to sleep. Resident #1 told staff person C that he/she had been grabbed by the chin, and pushed back hard on the bed. Staff person C stated that resident #1 "appeared scared and kept holding [redacted] jaw." Staff persons A and C failed to implement the home's resident abuse policy, and did not immediately report the incident to the home's administrator, but waited until after their shift ended at 6:00 a.m. on 04/27/11. On 04/27/11, staff person B provided unsupervised care of residents in the home between 2:00 a.m. - 6:00a.m. The home began an internal investigation on 04/27/11 at 1:00 p.m., and staff person B was suspended until terminated by the home.  <b>Western Region</b>  JUL 29 2011	4/27/11  8/18/11	On April 27, 2011, the Executive Director received a report of suspected abuse concerning resident # 1. The Executive Director conducted a thorough investigation into the allegation. The Department of Welfare, Area on Aging and the resident's family were notified of the incident. Staff member C was suspended pending the investigation. The allegation of abuse was substantiated and staff member C was terminated.  From June 15 thru June 23, 2011, the Executive Director and/or Director of Resident Care Services conducted in-services with all staff members to discuss Resident Rights, 2600.201 Safe Management Techniques, and Resident Abuse Reporting and the requirement of immediately reporting suspected abuse to a supervisor. (See attached) In addition, as part of our ongoing staff education, there is an Elder Abuse and Neglect. in-service scheduled for August 18, 2011. This training will be provided by [redacted] RN from Gallagher Home Health.	

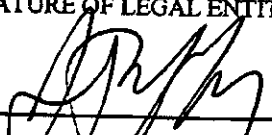

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15b If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.	On 04/27/11, at approximately 2:00a.m., staff person A overheard staff person B yelling at resident #1 to lay back down and go to sleep. Resident #1 told staff person C that he/she had been grabbed by the chin, and pushed back hard on the bed. Staff person C stated that resident #1 "appeared scared and kept holding [redacted] jaw." Staff persons A and C failed to implement the home's resident abuse policy, and did not immediately report the incident to the home's administrator, but waited until after their shift ended at 6:00 a.m. on 04/27/11. On 04/27/11, staff person B provided unsupervised care of residents in the home between 2:00 a.m. - 6:00a.m. The home began an internal investigation on 04/27/11 at 1:00 p.m., and staff person B was suspended until terminated by the home.	4/27/11	On April 27, 2011, the Executive Director received a report of suspected abuse concerning resident # 1. The Executive Director conducted a thorough investigation into the allegation. The Department of Welfare, Area on Aging and the resident's family were notified of the incident. Staff member C was suspended pending the investigation. The allegation of abuse was substantiated and staff member C was terminated.  From June 15 thru June 23, 2011, the Executive Director and/or Director of Resident Care Services conducted in-services with all staff members to discuss Resident Rights, 2600.201 Safe Management Techniques, and Resident Abuse Reporting and the requirement of immediately reporting suspected abuse to a supervisor. (See attached) In addition, as part of our ongoing staff education, there is an Elder Abuse and Neglect. in-service scheduled for August 18, 2011. This training will be provided by [redacted]	
	Western Region  JUL 29 2011	8/18/11		Steps have been taken to correct violation; full compliance is not verifiable Date: 8-5-11 Initials (DPW)

Adult Residential Licensing

[redacted] RN from Gallagher Home Health.

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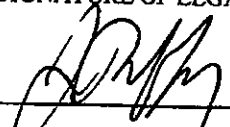

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- ② Report the alleged abuse to the Department.
- ③ Report the alleged abuse to the local Area Agency on Aging.
- ④ Report the alleged abuse to the resident's designated person, if any.
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REGULATION 55 Pa.Code §2600	VIOLATION	DATE COMPLIANCE VERIFIED BY	PLAN OF CORRECTION	DATE COMPLIANCE VERIFIED BY
42b A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.	On 04/27/11, at approximately 2:00a.m., staff person A overheard staff person B yelling at resident #1 to lay back down and go to sleep. Resident #1 told staff person C that he/she had been grabbed by the chin, and pushed back hard on the bed. Staff person C stated that resident #1 "appeared scared and kept holding [redacted] jaw." Staff persons A and C failed to implement the home's resident abuse policy, and did not immediately report the incident to the home's administrator, but waited until after their shift ended at 6:00 a.m. on 04/27/11. Staff person B provided unsupervised care of residents in the home between 2:00 a.m. - 6:00a.m. The home began an internal investigation on 04/27/11 at 1:00 p.m., and staff person B was suspended until terminated by the home.	4/27/11	On April 27, 2011, the Executive Director received a report of suspected abuse concerning resident # 1. The Executive Director conducted a thorough investigation into the allegation. The Department of Welfare, Area on Aging and the resident's family were notified of the incident. The suspected employee was suspended pending the investigation. The investigation revealed that staff member D while providing resident care. The allegation of abuse was substantiated and the employee was terminated.	
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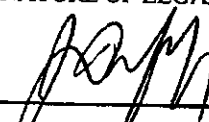

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VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa. Code Chapter 2600

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