pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: January 27, 2016

Ms. Vicki Loucks, Vice President
Redstone Senior Care
126 Matthews Street
Greensburg, Pennsylvania 15601

RE: Redstone Highlands
12921 Redstone Drive
North Huntingdon, Pennsylvania 15642
License # 443370

Dear Ms. Loucks:

As a result of the Department of Human Services' licensing inspection on December 23, 2014, of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

PCH Name: Redstone Highlands	License Number: 44337
Address: 12921 Redstone Drive, North Huntingdon, PA 15642	County: Westmoreland
Administrator: Lee Bach	Region: WEST
Legal Entity Name: Redstone SeniorCare	
Legal Entity Address: 126 MATHEWS STREET, GREENSBURG, PA 15601	

Certificate(s) of Occupancy
C-2 LP
10/26/2001
L&I

Staffing Hours

Resident Support: 0	Total Daily Staff: 69	Waking Staff: 52
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Incident

On-Site Inspections Dates and Department Representatives On-Site
12/23/2014: Marini, Michael; Park, Beth

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers:	Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 40	Number of Residents who:
Number of Residents Served: 39	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 39
Area: SDU area	Have Mental Illness: 0
Secured Dementia Unit Capacity, if Applicable: 20	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, if applicable: 20	Have a Mobility Need: 30
Number of Current Hospice Residents: 3	Have a Physical Disability: 1
Number of Hospice Residents in past year: 12	

Violation Report: 44337 - 12/23/2014 - Marini, Michael
PCH Name: Redstone Highlands

1. REGULATION 55 Pa.Code §2600

2600.15(a) - The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.701 - 10225.707) and 6 Pa. Code Sections 15.21 - 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

2a. DESCRIPTION OF VIOLATION

*On 11-28-14, resident #1 was touching and groping resident #2 and was grabbing resident #2's hips. Resident #2 was very upset.

*On 11-30-14 resident #1 grabbed resident #3's arms and chest area.

*On 12-14-14 resident #1 was in the living room of the secure dementia care unit rubbing resident #4's knee and thigh.

The home failed to report these incidents to the Area Agency on Aging as required by the Older Adult Protective Services Act.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Please see attached

See page 2a + 2b of 6

Repeat Violation: No	Date(s) of Previous Violation(s):		

Signature of Legal Entity Representative (Required on EVERY Page) Leigh Bach

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Leigh Bach

Date 1-6-16

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 1/25/16 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 1/25/16 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report 44337 – 12/23/14 – Michael Marini

PCH Name – Redstone Highlands

Regulation Violation 2600.15(a)

Plan of Corrections:

This PCH takes very seriously the reporting requirements outlined by The Commonwealth of Pennsylvania - Pennsylvania Code Chapter 2600. It is understood that all cases of suspected abuse must be reported to the Area Agency on Aging as required by the Older Adult Protective Services Act. It is the position of this PCH that no abuse was suspected in the circumstances that prompted the visit from BHSL on 12/23/14 therefore no report was made to the Area Agency on Aging.

Resident #1 was transferred to this PCH from our Greensburg Campus on [redacted]14 due to increased safety concerns regarding way finding difficulties and was thus determined to be in need of a secured dementia community. This resident had no history of difficult interactions with other residents. Shortly after arriving it was discovered that one of our [redacted] residents bore a striking resemblance (according to family reports) to Resident #1's deceased [redacted]. When resident #1's beliefs were challenged the result was verbal arguments and a number of occasions when staff was the target of physical frustration. At all times residents were protected from harm including Resident #1 who at times was the target of verbal accusations from other residents. This PCH recognized the concerns of all stake holders including family and staff.

At no time did this PCH consider this difficult period of adjustment as suspected abuse as defined by the Pennsylvania Code and did not report it as such. This PCH contacted a number of resources during this time period including the Provider Hot Line, Temple University and the Aging Institute; none of these resources recommended this PCH treat these circumstances as an allegation of abuse.

This PCH did recognize needs in two areas as a result of these circumstances: 1. A need for better understanding of various types of dementia and positive approaches. 2. Partnership with Geriatric Psychiatry to better manage the disease. This POC will focus on these needs in answer to this violation.

What change was made: This administrator engaged the consulting services of [redacted] with UPMC's Aging Institute to provide detailed dementia education and positive approaches to the responses of those suffering from the disease.

Who made the change: Campus Director

When was the change made: January 3,2015

How was the change made / system changes / staff training: On 2/26/15 the Aging Institute provided training (see Exhibit 1) to all staff assigned to the PCH SDU. Exhibit 2 documents the resources provided in consultation with the Aging Institute in addition to the face to face training. Additional training

Lisa L Rock
1-6-16

Violation Report 44337 – 12/23/14 – Michael Marini

PCH Name – Redstone Highlands

Regulation Violation 2600.15(a)

throughout the year included the Aging Institute Geriatric Resource Nurse Training and the PA Culture Change Coalition ACCORD conference. This PCH also adopted permanent staff assignments on 12/20/14 in an effort to improve knowledge of each individual resident and develop positive approaches to each of their reactions. Household committees were also formed in 2015 for the staff to share best practices and brainstorm solutions to challenges within the community. Residents, to the degree that they can and wish to participate, are encouraged to provide input as well. These committees continue to meet weekly.

Unfortunately despite many attempts, this PCH is still in need of a partnership with a Geriatric Psychiatrist. All resources contacted including the Provider Hotline, Temple University and the Aging Institute have acknowledged scarcity in this area despite a growing need.

Immediately - The administrator will ensure that all incidents or allegations of resident abuse are reported in accordance with the Older Adult Protective Services Act. JW 1/25/16

Leigh Bach
1-6-16

Violation Report: 44337 - 12/23/2014 - Marini, Michael
PCH Name: Redstone Highlands

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

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 section 2600.15 (relating to abuse reporting covered by law).

2a. DESCRIPTION OF VIOLATION

On 11-28-14 resident #1 was touching and groping resident #2 and was grabbing resident #2's hips. Resident #2 was very upset. The home failed to report this incident to the Department.

On 11-30-14 resident #1 was grabbing resident #3's arms and chest area. The home failed to report this incident to the Department until 12-16-14.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Please see attached

See Page 3a of 6

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Date 1-6-16

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- ☑ Partially Implemented - Adequate Progress JW
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- ☐ Not Implemented

Page 3a of 6

Violation Report 44337 – 12/23/14 – Michael Marini

PCH Name – Redstone Highlands

Regulation Violation 2600.16(c)

Plan of Corrections:

This PCH strives to comply with timely reporting requirements outlined by The Commonwealth of Pennsylvania - Pennsylvania Code Chapter 2600. Three incident reports relating to circumstances occurring this time period were filed with the Bureau of Human Services Licensing. The purpose of these reports was to provide the Bureau with a summary of the cumulative difficult circumstances. None were filed as reports of abuse as it is the position of this PCH that no abuse was suspected in these circumstances.

Additionally this PCH contacted a number of resources during this time period including the Provider Hot Line, Temple University and the Aging Institute; none of these resources recommended this PCH treat these circumstances as an allegation of abuse.

This plan of corrections will support continued observation of timely reporting.

What change was made: Continue to emphasize timely incident reporting.

Who made the change: Campus Director and Personal Care Manager will continue to monitor.

When was the change made: Ongoing

How was the change made / system changes / staff training: Staff are instructed to alert management via e mail and text messaging which are monitored timely.

Immediately - The administrator will ensure that reportable incidents are reported to the Department within 24 hours. DW, 1/25/16

Leigh Bock

1-26-16

Violation Report: 44337 - 12/23/2014 - Marini, Michael
PCH Name: Redstone Highlands

1. REGULATION 55 Pa.Code §2600

2600.202 - The following procedures are prohibited:

(1) Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited.

(2) Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.

(3) Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.

(4) A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited.

(5) A mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited.

(6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

2a. DESCRIPTION OF VIOLATION

Resident #1 is prescribed "Ativan-1 mg/ml-Inject 0.5 ml intramuscularly every 12 hours as needed for depression" and "Ativan-1 mg-1 tablet by mouth twice a day as needed if inappropriate behavior and staff is unable to administer Ativan by injection". Staff interviews indicate Ativan is administered to resident #1 to control behaviors. This is considered a chemical restraint.

According to progress notes in resident #1'S record, Ativan was administered to the resident on the following dates:

12-5-14 7:31 PM- Resident was upsetting other residents by confusing them for [his/her spouse]. The...residents did not want [his/her] attention but when staff tried to redirect [resident #1] became very angry and began hitting staff. Ativan IM was administered with very good results. [Resident #1] stayed in [his/her] room the rest of the night just opening [his/her] door frequently to look out.

12-6-14 6:15 PM- Resident got up out of w/c and was chasing after resident #5 and scaring [him/her].... [He/she] was given IM injection of Ativan 0.5 ml in the left deltoid at 6:15 pm for behavior. Removed [him/her] from other residents and kept [him/her] close to staff.

12-7-14 3:30 PM- ...[Resident #1] Did get agitated when [redacted] saw [resident #2] around 3:30 pm. Was given oral Ativan 1 mg.

12-22-14 5:00 AM- ... Resident was awake around 5 am.... [He/she] started banging on the inside of [his/her] door. [Staff] entered and [he/she] was beginning to get agitated. [He/she] went to the window and was trying to open it. I assisted CNA to try to redirect [him/her], but [he/she] was still agitated. I administered Lorazapam [sic] 1 mg tab.

See page 5a of 6

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☑ Partially Implemented - Adequate Progress JL

Page 5a of 6

Violation Report 44337 – 12/23/14 – Michael Marini

PCH Name – Redstone Highlands

Regulation Violation 2600.202

Plan of Corrections:

What change was made: An audit was conducted on all PCH residents medical records. There are no existing orders that direct use of psychotropic medications for the purpose of modifying behavior. Redstone Highlands is a restraint free community and does not promote or allow the use of medications as a means of restraint.

Significant investment is made to provide staff with education and resources to respond to the unique challenges of each resident. Redstone Highlands embraces a culture of person directed care and actively participates in the PA Culture Change Coalition.

At the time of the circumstances outlined in this violation report this PCH provided the staff with additional training through the UPMC Aging Institute. This training provided non pharmacological approaches to challenging resident reactions as well as a deeper understanding of the dementia disease process. Staff was provided with additional education opportunities through the Aging Institute Geriatric Resource Nurse Training and the PA Culture Change Coalition ACCORD conference.

This PCH also adopted permanent staff assignments on 12/20/14 in an effort to improve knowledge of each individual resident and develop positive approaches to each of their reactions. Household committees were formed in 2015 for the staff to share best practices and brainstorm solutions to challenges within the community. Residents, to the degree that they can and wish to participate, are encouraged to provide input as well. These committees continue to meet weekly.

Who made the change: Campus Director and Personal Care Manager

When was the change made: Throughout 2014 - present

How was the change made / system changes / staff training: In addition to the actions previously taken this regulation will be reviewed at the next PCH staff meeting on 1/21/16.

Leigh Bach

1-6-16

Violation Report: 44337 - 12/23/2014 - Marini, Michael
PCH Name: Redstone Highlands

1. REGULATION 55 Pa.Code §2600

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