



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: September 29, 2016

Ms. Loriann Putzier, COO
Tithonus Butler, LP
c/o Integracare Corporation
6600 Brooktree Court, Suite 1000
Wexford, Pennsylvania 15090

RE: Newhaven Court at Clearview
100 Newhaven Lane
Butler, Pennsylvania
Certificate/License #423460

Dear Ms. Putzier:

As a result of the Department of Human Services' licensing inspection on February 2, 2016, 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,

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report: 42346 - 02/02/2016 - Pfaff, Vicki
 PCH Name: NEWHAVEN COURT AT CLEARVIEW

WEST REGION FIELD OFFICE
 Human Services Licensing

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

During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person D witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please no swearing". Direct care staff person A witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

During the week of 12/21/15 on the 3:00 p.m. to 11:30 p.m. direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up your fucking spoon and feed yourself" at resident #2. Direct care staff person D witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

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.

See pages 2A and 2B of 5

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Gary Penwick*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Gary Penwick, Executive Director* Date *9-12-16*

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

The above plan of correction is approved as of <u>9-19-16</u> (Date)	Plan of correction implementation status as of <u>9-19-16</u> (Date)
The above plan of correction was approved by <u>g</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress ✓ <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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WEST REGION FIELD OFFICE
Human Services Licensing

Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 2/2/16
Date of Submission: 9/14/16

1. Violation Review: 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.

2. Review the Citation, the violation of the Regulation:

- During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00pm to 11:00pm shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person D witnessed the incident. This incident was not report to the area agency on Aging until 1/8/16.

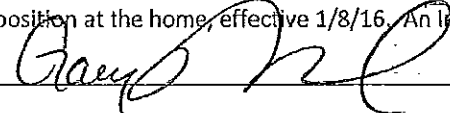
Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00pm to 11:00pm shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please not swearing". Direct care staff person A witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

During the week of 12/21/15 on the 3:00pm to 11:00pm direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up you fucking spoon and feed yourself" at resident #2. Direct care staff person D witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

3. Description of the Repair of the Immediate Problem:

- Once the home was informed of the alleged verbal abuse on 1/8/16, an immediate investigation was conducted. Staff person C was immediately suspended pending the results of the investigation. Written statements were obtained from Staff persons A & D which indicate that Staff Person C used vulgar and inappropriate language that maybe regarded as verbal abuse. Following a thorough investigation, the home was able to substantiate from the corroborating witnessed accounts that the allegations are true and in fact did occur. The POA/Family member of Resident #1 was immediately notified. Verbal report to Older Adult Protective Services followed by a written ACT 13 report to OAPS. Staff Person C was immediately terminated from her position at the home, effective 1/8/16. An Initial and Final Reportable Incident was sent to

Authorized Signature  Date: 9-12-16

Plan of Correction Template

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9-14-16d

DHS. Resident #1 resided in our Special Needs area of the home. [redacted] had significant cognitive impairment and physical care needs and was unable to recollect the events or understand the seriousness of the situation. Resident #2 was no longer a resident at the home at the time the alleged verbal abuse was reported to management at the home.

4. Detail Action Steps / System Developed to prevent future occurrence and Designated position responsible with target dates for completion:

- Staff education on Resident Rights and Mandatory Reporting conducted by Butler County Ombudsman [redacted] and Older Adult Protective services rep [redacted] on 2/4/16. Staff persons A & D in attendance. See attached documentation.
- Staff Training via Relias On-line Academy assigned to all staff persons in February 2016, as part of the annual training plan on Resident Rights and Preventing, Recognizing, and Reporting Abuse. See attached Documentation.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during General Orientation for new hires as it relates to the regulation and company standard. See attached documentation.
- Documentation of staff education shall be kept on file.
- The ED and Assistant ED will continue to monitor this training is completed annually and as part of the new hire orientation for new staff persons.

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WEST REGION FIELD OFFICE
Human Services Licensing

Immediately: The administrator will review all reported incidents and any allegations of abuse at least weekly to ensure any allegations of abuse and reportable incidents are reported in accordance with the Older Adult Protective Services Act and the Department of Human Services regulations. 9-14-16

Authorized Signature [Handwritten Signature]

Date: 9-14-16

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Violation Report: 42346 - 02/02/2016 - Pfaff, Vicki PCH Name: NEWHAVEN COURT AT CLEARVIEW	WEST REGION FIELD OFFICE Human Services Licensing
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1. REGULATION 55 Pa.Code §2600

2600.15(b) - 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.

2a. DESCRIPTION OF VIOLATION

During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #1 and other residents in the home.

Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please no swearing". Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #2 and other residents in the home.

During the week of 12/21/15 on the 3:00 p.m. to 11:30 p.m. direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up your fucking spoon and feed yourself" at resident #2. Direct care staff person D witnessed the incident. Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #2 and other residents in the home.

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.

See pages 3A and 3B of 5

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page)	<i>[Signature]</i>
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Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Gary Kenwick, Executive Director</i>	<i>9-12-16</i>

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The above plan of correction is approved as of <u>9-19-16</u> (Date)	Plan of correction implementation status as of <u>9-19-16</u> (Date)
The above plan of correction was approved by <u>f</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress ✓ <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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WEST REGION FIELD OFFICE
Human Services Licensing

Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 2/2/16
Date of Submission: 9/14/16

1. Violation Review: 2600.15(b) -

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.

2. Review the Citation, the violation of the Regulation:

- During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00pm to 11:00pm shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #1 and other residents in the home.

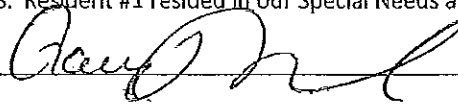
Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00pm to 11:00pm shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please not swearing". Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #2 and other residents in the home.

During the week of 12/21/15 on the 3:00pm to 11:00pm direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up you fucking spoon and feed yourself" at resident #2. Direct care staff person C was not placed on a plan of supervision or suspended and continued to provide direct care services to resident #2 and other residents in the home.

3. Description of the Repair of the Immediate Problem:

- Once the home was informed of the alleged verbal abuse on 1/8/16, an immediate investigation was conducted. Staff person C was immediately suspended pending the results of the investigation. Written statements were obtained from Staff persons A & D which indicate that Staff Person C used vulgar and inappropriate language that maybe regarded as verbal abuse. Following a thorough investigation, the home was able to substantiate from the corroborating witnessed accounts that the allegations are true and in fact did occur. The POA/Family member of Resident #1 was immediately notified. Verbal report to Older Adult Protective Services followed by a written ACT 13 report to OAPS. Staff Person C was immediately terminated from her position at the home, effective 1/8/16. An Initial and Final Reportable Incident was sent to DHS. Resident #1 resided in our Special Needs area of the home. [redacted] had significant cognitive

Authorized Signature 

Date: 9-12-16

9-19-16g

impairment and physical care needs and was unable to recollect the events or understand the seriousness of the situation. Resident #2 was no longer a resident at the home at the time the alleged verbal abuse was reported to management at the home.

4. Detail Action Steps / System Developed to prevent future occurrence and Designated position responsible with target dates for completion:

- Staff education on Resident Rights and Mandatory Reporting conducted by Butler County Ombudsman [redacted] and Older Adult Protective services rep [redacted] on 2/4/16. Staff persons A & D in attendance. See attached documentation.
- Staff Training via Relias On-line Academy assigned to all staff persons in February 2016, as part of the annual training plan on Resident Rights and Preventing, Recognizing, and Reporting Abuse. See attached Documentation.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during General Orientation for new hires as it relates to the regulation and company standard. See attached documentation.
- Documentation of staff education shall be kept on file.
- The ED and Assistant ED will continue to monitor this training is completed annually and as part of the new hire orientation for new staff persons.

Immediately: The administrator will review all reported incidents and any allegations of abuse at least weekly to ensure the home has immediately placed the accused staff person on a plan of supervision which includes not having access to any residents without the presence of another qualified direct care staff person, any plan of supervision shall have the pre-approval of the Department, or the home has suspend the staff person or persons involved.

9-19-16

Authorized Signature 

Date: 9-12-16

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Violation Report: 42346 - 02/02/2016 - Pfaff, Vicki
PCH Name: NEWHAVEN COURT AT CLEARVIEW

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

During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person D witnessed the incident. This incident was not reported to the Department until 1/8/16.

Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please no swearing". Direct care staff person A witnessed the incident. This incident was not reported to the Department until 1/8/16.

During the week of 12/21/15 on the 3:00 p.m. to 11:30 p.m. direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up your fucking spoon and feed yourself" at resident #2. Direct care staff person D witnessed the incident. This incident was not reported to the Department until 1/8/16

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.

see pages 4 & 14B of 5

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

Signature of Legal Entity Representative (Required on EVERY Page) *[Signature]*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Gary Remisch, Executive Director* Date *9-12-16*

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The above plan of correction is approved as of 9-19-16 (Date)

Plan of correction implementation status as of 9-19-16 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *g*
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *g* (Initials)

Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 2/2/16
Date of Submission: 9/14/16

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SEP 12 2016

WEST REGION FIELD OFFICE
Human Services Licensing

1. Violation Review: 2600.16(c) -

The 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.)

2. Review the Citation, the violation of the Regulation:

- During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00pm to 11:00pm shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1. Direct care staff person D witnessed the incident. This incident was not report to the area agency on Aging until 1/8/16.

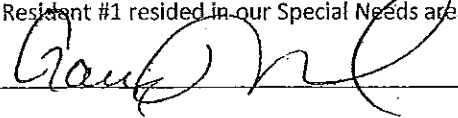
Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00pm to 11:00pm shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please not swearing". Direct care staff person A witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

During the week of 12/21/15 on the 3:00pm to 11:00pm direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up you fucking spoon and feed yourself" at resident #2. Direct care staff person D witnessed the incident. This incident was not reported to the area agency on Aging until 1/8/16.

3. Description of the Repair of the Immediate Problem:

- Once the home was informed of the alleged verbal abuse on 1/8/16, an immediate investigation was conducted. Staff person C was immediately suspended pending the results of the investigation. Written statements were obtained from Staff persons A & D which indicate that Staff Person C used vulgar and inappropriate language that maybe regarded as verbal abuse. Following a thorough investigation, the home was able to substantiate from the corroborating witnessed accounts that the allegations are true and in fact did occur. The POA/Family member of Resident #1 was immediately notified. Verbal report to Older Adult Protective Services followed by a written ACT 13 report to OAPS. Staff Person C was immediately terminated from her position at the home, effective 1/8/16. An Initial and Final Reportable Incident was sent to DHS. Resident #1 resided in our Special Needs area of the home [redacted] had significant cognitive

Authorized Signature 

Date: 9-12-16

9-19-16g

impairment and physical care needs and was unable to recollect the events or understand the seriousness of the situation. Resident #2 was no longer a resident at the home at the time the alleged verbal abuse was reported to management at the home.

4. Detail Action Steps / System Developed to prevent future occurrence and Designated position responsible with target dates for completion:

- Staff education on Resident Rights and Mandatory Reporting conducted by Butler County Ombudsman [redacted] and Older Adult Protective services rep [redacted] on 2/4/16. Staff persons A & D in attendance. See attached documentation.
- Staff Training via Relias On-line Academy assigned to all staff persons in February 2016, as part of the annual training plan on Resident Rights and Preventing, Recognizing, and Reporting Abuse. See attached Documentation.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during General Orientation for new hires as it relates to the regulation and company standard. See attached documentation.
- Documentation of staff education shall be kept on file.
- The ED and Assistant ED will continue to monitor this training is completed annually and as part of the new hire orientation for new staff persons.

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WEST REGION FIELD OFFICE
Human Services Licensing

Immediately: The administrator or designee will review all reportable incidents and conditions at least weekly, including any allegations of abuse, to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c. 9-19-16

Authorized Signature [Handwritten Signature]

Date: 9-12-16

Plan of Correction Template

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Violation Report: 42346 - 02/02/2016 - Pfaff, Vicki
PCH Name: NEWHAVEN COURT AT CLEARVIEW

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.42(c) - A resident shall be treated with dignity and respect.

2a. DESCRIPTION OF VIOLATION

During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1.

Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00 p.m. to 11:00 p.m. shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please no swearing".

During the week of 12/21/15 on the 3:00 p.m. to 11:30 p.m. direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up your fucking spoon and feed yourself" at resident #2.

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.

See pages 5A and 5B of 16

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

Signature of Legal Entity Representative
(Required on EVERY Page) *Gary Kenwick*

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Gary Kenwick, Executive Director* Date *9-12-16*

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The above plan of correction is approved as of <u>9-19-16</u> (Date)	Plan of correction implementation status as of <u>9-19-16</u> (Date)
The above plan of correction was approved by <u><i>G</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress ✓ <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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WEST REGION FIELD OFFICE
Human Services Licensing

Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 2/2/16
Date of Submission: 9/14/16

1. Violation Review: 2600.42(c) -

A resident shall be treated with dignity and respect.

2. Review the Citation, the violation of the Regulation:

- During November 2015 and December 2015, there were several incidents when direct care staff person C treated resident in a disrespectful manner.

Resident #1 has a significant cognitive impairment and requires staff assistance to transfer and to use the toilet.

On 12/16/16 or 12/17/16, during the 3:00pm to 11:00pm shift, direct care staff person C was assisting resident #1 with toileting. Staff person C yelled "stand up on your fucking feet" at resident #1


Resident #2 requires staff assistance with eating and drinking, to transfer, and to use the toilet.

Approximately the third week in November 2015, during the 3:00pm to 11:00pm shift, direct care staff person C was providing assistance with toileting to resident #2. Staff person C asked the resident to stand up. Resident #2 stated he/she could not. Staff person C told resident #2 "stand the fuck up, don't pretend you can't do it". Resident #2 replied "please not swearing".

During the week of 12/21/15 on the 3:00pm to 11:00pm direct care staff person C was providing with assistance with feeding to resident #2. Direct care staff person C yelled "pick up you fucking spoon and feed yourself" at resident #2.

3. Description of the Repair of the Immediate Problem:

- Once the home was informed of the alleged verbal abuse on 1/8/16, an immediate investigation was conducted. Staff person C was immediately suspended pending the results of the investigation. Written statements were obtained from Staff persons A & D which indicate that Staff Person C used vulgar and inappropriate language that maybe regarded as verbal abuse. Following a thorough investigation, the home was able to substantiate from the corroborating witnessed accounts that the allegations are true and in fact did occur. The POA/Family member of Resident #1 was immediately notified. Verbal report to Older Adult Protective Services followed by a written ACT 13 report to OAPS. Staff Person C was immediately terminated from her position at the home, effective 1/8/16. An Initial and Final Reportable Incident was sent to DHS. Resident #1 resided in our Special Needs area of the home. [redacted] had significant cognitive impairment and physical care needs and was unable to recollect the events or understand the seriousness of the situation. Resident #2 was no longer a resident at the home at the time the alleged verbal abuse was reported to management at the home.

Authorized Signature 

Date: 9-12-16

9-14-16

Page 5 B of 5

4. Detail Action Steps / System Developed to prevent future occurrence and Designated position responsible with target dates for completion:

- Staff education on Resident Rights and Mandatory Reporting conducted by Butler County Ombudsman [redacted] and Older Adult Protective services rep [redacted] on 2/4/16. Staff persons A & D in attendance. See attached documentation.
- Staff Training via Relias On-line Academy assigned to all staff persons in February 2016, as part of the annual training plan on Resident Rights and Preventing, Recognizing, and Reporting Abuse. See attached Documentation.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during General Orientation for new hires as it relates to the regulation and company standard. See attached documentation.
- Documentation of staff education shall be kept on file.
- The ED and Assistant ED will continue to monitor this training is completed annually and as part of the new hire orientation for new staff persons.

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Human Services Licensing

Immediately: The administrator will privately interview at least two residents a week for three months and biannually thereafter to ensure residents are treated with dignity and respect. Documentation of interviews will be kept.

7-19-16g

Authorized Signature 

Date: 9-12-16

9-19-16g