



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: February 1, 2017

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 December 8, 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,

A handwritten signature in black ink that reads "Jason Williams" with a stylized flourish at the end.

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

PCH Name: NEWHAVEN COURT AT CLEARVIEW		License Number: 42346
Address: 100 NEWHAVEN LANE, BUTLER, PA 16001		County: Butler
Administrator: Gary Renwick		Region: WEST
Legal Entity Name: TITHONUS BUTLER LP		RECEIVED
Legal Entity Address: 8800 BROOKTREE COURT SUITE 1000, WEXFORD, PA 15090		
Certificate(s) of Occupancy C-2 LP 05/05/1997 Labor & Industry		JAN 09 2017 WEST REGION FIELD OFFICE Human Services Licensing
Staffing Hours		
Resident Support: N/A	Total Daily Staff: 122	Waking Staff: 92
Type of Inspection: Partial	BHA Docket Number: N/A	Notice: Unannounced
Reason(s) for Inspection(s)		
Incident		
On-Site Inspections Dates and Department Representatives On-Site		
12/08/2016: Park, Beth; Garvey, Jody		
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: 115 Number of Residents Served: 89 Secured Dementia Care Unit In Home: Yes Area: Pathways Secured Dementia Unit Capacity, If Applicable: 18 Number of Residents Served In Secured Dementia Care Unit, if applicable: 16 Number of Current Hospice Residents: 5 Number of Hospice Residents in past year: 20	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 87 Have Mental Illness: 0 Have an Intellectual Disability: 0 Have a Mobility Need: 33 Have a Physical Disability: 0	

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Violation Report: 42346 - 12/08/2016 - Park, Beth
 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
 On 11/19/2016 at approximately 8:00 p.m., staff person A entered resident #1's room in response to the resident activating his/her call bell for assistance. Resident #1 stated he/she was forced out of his/her clothes and into his/her night clothes after telling staff person A that he/she did not want to get ready for bed. Resident #1 stated he/she felt very uncomfortable, violated and afraid.
 Resident #1 reported this to 2 other direct care staff shortly after the incident; however, the home did not report the incident to the Department until 11/22/2016.

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 2^a of 4 and 2^b of 4

Repeat Violation: Yes	Date(s) of Previous Violation(s):	02/02/2016
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Gay Owen*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Gay Penwick, Executive Director</i>	Date <i>1-9-17</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>1/19/17</u> (Date)	Plan of correction implementation status as of <u>1/19/17</u> (Date)
The above plan of correction was approved by <u>GW</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>GW</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

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Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 12/8/16
Date of Submission: 1/9/17

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WEST REGION FIELD OFFICE
Human Services Licensing

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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:

- On 11/19/16 at approximately 8:00pm, staff person A entered resident #1's room in response to the resident activating his/her call bell for assistance. Resident #1 stated he/she was forced out of his/her clothes and into his/her night clothes after telling staff person A that he/she did not want to get ready for bed. Resident #1 stated he/she felt very uncomfortable, violated and afraid.

Resident #1 reported this to 2 other direct care staff shortly after the incident; however, the home did not report the incident to the Department until 11/22/16.

3. Description of the Repair of the Immediate Problem:

- Two other direct care staff as listed above reported an incident that occurred on Saturday evening, 11/19/16 at approximately 8:00 p.m. Staff person A, who was hired on [redacted] 16 and was working on the floor on [redacted] first day of supervised training. Staff person A responded to the call bell of Resident listed above at approximately 8:00pm. Resident requires physical assist x 1 for care, but is alert and oriented x 3. Staff person A completed care for Resident and exited the apt. after approximately 15 minutes. Staff person A then reported to two other direct care staff that the resident requested to get ready for bed and during the assist became upset and agitated. Upon hearing this information, and because it was contrary to the Resident's normal routine, the two other direct care staff followed up with Resident. Resident reported that staff person A was insistent that [redacted] get ready for bed and that felt like [redacted] was being forced to remove [redacted] clothes to get ready for bed. The resident also reported that [redacted] felt disrespected and fearful. Resident communicated that at no time was [redacted] physically harmed, but that [redacted] did feel [redacted] was being forced to get ready for bed, when this was not [redacted] request. The request was made for assistance to the bathroom, and the two other direct care staff did complete this care. Upon hearing this information, the two other direct care staff immediately reported the information regarding the incident as stated above to the Charge Nurse on duty. Charge Nurse made sure staff person A was directly supervised for remainder of shift and did not complete care alone and provided assist and support to all RCA's on duty. No further incidents were reported for remainder of assigned shifts (2 total).

After being made aware of this incident on 11/21/16, the ED & DRCS immediately began an investigation. Interviews with all individuals listed above were conducted and written statements were obtained. [redacted] at OAPS was called to inform of incident, and guidance was requested as to whether an ACT 13 Report was required in this case. The ED & DRCS were informed by the OAPS Representative that an ACT 13 report was not needed. OAPS official provided instruction for us to offer Resident to speak to the Ombudsman and follow up with DHS reporting. After completing investigation, staff person A's employment was terminated. Charge

Authorized Signature [Signature]

Date: 1-9-17

JL 1/19/17

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Nurse involved in this incident to be immediately retrained on Resident Rights and reporting requirements. Documentation of training will be sent to DHS when completed and kept on file in the home. Family and physician were notified of incident.

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 Area Agency on Aging Clinical Supervisor [redacted] on 12/20/16 and reinforced by [redacted] Executive Director. See attached documentation.
- Retraining on Resident Rights, Elder abuse, and mandatory reporting reviewed with Charge Nurse involved in this incident on 11/22/16. Documentation of training attached and kept on file.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during monthly department meetings throughout 2017. Documentation of monthly staff meetings shall be kept on file. See attached Monthly Department Meeting summary.
- The ED and Assistant ED will continue to monitor this training is completed monthly, annually and as part of the new hire orientation for new staff persons.

All staff persons received training on 12/20/16 on residents' rights and reporting and preventing resident abuse by a Department-approved outside source. *gms. 1/19/17*

Within 30 days of receipt of the plan of correction: All staff persons will receive a monthly training on residents' rights and reporting and preventing resident abuse. Documentation of the trainings shall be kept. *gms. 1/19/17*

Authorized Signature *GauDne*

Date: 1-9-17

gms. 1/19/17

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Violation Report: 42346 - 12/08/2016 - Park, Beth
PCH Name: NEWHAVEN COURT AT CLEARVIEW

1. REGULATION 55 Pa.Code §2800
2800.42(c) - A resident shall be treated with dignity and respect.

JAN 09 2017

WEST REGION FIELD OFFICE
Human Services Licensing

2a. DESCRIPTION OF VIOLATION

On 11/19/2016 at approximately 8:00 p.m., staff person A entered resident #1's room in response to the resident activating his/her call bell for assistance. Resident #1 stated he/she was forced out of his/her clothes and into his/her night clothes after telling staff person A that he/she did not want to get ready for bed. Resident #1 stated he/she felt very uncomfortable, violated and afraid.

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 3^a of 4 and 3^b of 4

Repeat Violation: Yes Date(s) of Previous Violation(s): 02/02/2016

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) *Gary Renwick, Executive Director*

Date *1-9-17*

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The above plan of correction is approved as of 1/19/17
(Date)

Plan of correction implementation status as of 1/19/17
(Date)

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

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

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Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 12/8/16
Date of Submission: 1/9/17

1. Violation Review: 2600.42(c) -

A resident shall be treated with dignity and respect.

2. Review the Citation, the violation of the Regulation

- On 11/19/16 at approximately 8:00pm, staff person A entered resident #1's room in response to the resident activating his/her call bell for assistance. Resident #1 stated he/she was forced out of his/her clothes and into his/her night clothes after telling staff person A that he/she did not want to get ready for bed. Resident #1 stated he/she felt very uncomfortable, violated and afraid.

3. Description of the Repair of the Immediate Problem:

Two other direct care staff as listed above reported an incident that occurred on Saturday evening, 11/19/16 at approximately 8:00 p.m. Staff person A, who was hired on [redacted] 16 and was working on the floor on [redacted] first day of supervised training. Staff person A responded to the call bell of Resident listed above at approximately 8:00pm. Resident requires physical assist x 1 for care, but is alert and oriented x 3. Staff person A completed care for Resident and exited the apt. after approximately 15 minutes. Staff person A then reported to two other direct care staff that the resident requested to get ready for bed and during the assist became upset and agitated. Upon hearing this information, and because it was contrary to the Resident's normal routine, the two other direct care staff followed up with Resident. Resident reported that staff person A was insistent that [redacted] get ready for bed and that felt like [redacted] was being forced to remove [redacted] clothes to get ready for bed. The resident also reported that [redacted] felt disrespected and fearful. Resident communicated that at no time was [redacted] physically harmed, but that [redacted] did feel [redacted] was being forced to get ready for bed, when this was not [redacted] request. The request was made for assistance to the bathroom, and the two other direct care staff did complete this care. Upon hearing this information, the two other direct care staff immediately reported the information regarding the incident as stated above to the Charge Nurse on duty. Charge Nurse made sure staff person A was directly supervised for remainder of shift and did not complete care alone and provided assist and support to all RCA's on duty. No further incidents were reported for remainder of assigned shifts (2 total). After being made aware of this incident on 11/21/16, the ED & DRCS immediately began an investigation. Interviews with all individuals listed above were conducted and written statements were obtained [redacted] [redacted] at OAPS was called to inform of incident, and guidance was requested as to whether an ACT 13 Report was required in this case. The ED & DRCS were informed by the OAPS Representative that an ACT 13 report was not needed. OAPS official provided instruction for us to offer Resident to speak to the Ombudsman and follow up with DHS reporting. After completing investigation, staff person A's employment was terminated. Charge Nurse involved in this incident to be immediately retrained on Resident Rights and reporting requirements. Documentation of training will be sent to DHS when completed and kept on file in the home. Family and physician were notified of incident.

Authorized Signature [Handwritten Signature]

Date: 1-9-17

Handwritten initials 1/19/17

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

- Same Action plan as indicated on previous violation above.
- Staff education on Resident Rights and Mandatory Reporting conducted by Butler County Area Agency on Aging Clinical Supervisor [REDACTED] on 12/20/16 and reinforced by [REDACTED] Executive Director. See attached documentation.
- Retraining on Resident Rights, Elder abuse, and mandatory reporting reviewed with Charge Nurse involved in this incident on 11/22/16. Documentation of training attached and kept on file.
- Resident Rights, Elder Abuse, and Mandatory Reporting reinforced during monthly department meetings throughout 2017. Documentation of monthly staff meetings shall be kept on file. See attached Monthly Department Meeting summary.
- The ED and Assistant ED will continue to monitor this training is completed monthly, annually and as part of the new hire orientation for new staff persons.

All staff persons received training on 12/20/16 on residents' rights and reporting and preventing resident abuse by a Department-approved outside source. *g.u. 1/19/17*

Within 30 days of receipt of the plan of correction: All staff persons will receive a monthly training on residents' rights and reporting and preventing resident abuse. Documentation of the trainings shall be kept. *g.u. 1/17/17*

Authorized Signature *[Handwritten Signature]*

Date: 1-9-17

g.u. 1/19/17

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JAN 09 2017

Violation Report: 42346 - 12/08/2016 - Park, Beth
 PCH Name: NEWHAVEN COURT AT CLEARVIEW

WEST REGION FIELD OFFICE
 Human Services Licensing

1. REGULATION 66 Pa.Code §2600

2600.65(d) - Direct care staff persons hired after April 24, 2008 may not provide unsupervised ADL services until completion of the following:

- (1) Training that includes a demonstration of job duties, followed by supervised practice.
- (2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
- (3) Initial direct care staff person training to include the following:
 - (i) Safe management techniques.
 - (ii) ADLs and IADLs.
 - (iii) Personal hygiene.
 - (iv) Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
 - (v) The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - (vi) Implementation of the initial assessment, annual assessment and support plan.
 - (vii) Nutrition, food handling and sanitation.
 - (viii) Recreation, socialization, community resources, social services and activities in the community.
 - (ix) Gerontology.
 - (x) Staff person supervision, if applicable.
 - (xi) Care and needs of residents with special emphasis on the residents being served in the home.
 - (xii) Safety management and hazard prevention.
 - (xiii) Universal precautions.
 - (xiv) The requirements of this chapter.
 - (xv) Infection control.
 - (xvi) Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

2a. DESCRIPTION OF VIOLATION

Direct care staff person A, hired [redacted] 6, was unsupervised while providing ADL care to resident #1 on 11/19/2016. Direct care staff person A had not yet completed a demonstration of job duties followed by supervised practice.

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^a of 4 and 4^b of 4

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

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

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Gary Renwick, Executive Director* Date *1-9-17*

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

The above plan of correction is approved as of 1/19/17
 (Date)

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

Plan of correction implementation status as of 1/19/17
 (Date)

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

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Community Name: Newhaven Court at Clearview
License Number: 423460
Date of Visit: 2/2/16
Date of Submission: 1/9/17

1. Violation Review: 2600.65(d) -

Direct care staff persons hired after April 24, 2006 may not provide unsupervised ADL services until the completion of the following:

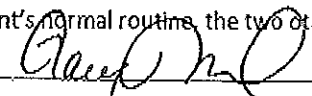
- (1) Training that includes a demonstration of job duties, followed by supervised practice.
- (2) Successful completion and passing the Department-approved direct care training course and passing of the competency test.
- (3) Initial direct care staff person training to include the following:
 - i. Safe management techniques.
 - ii. ADLs and IADLs.
 - iii. Personal hygiene.
 - iv. Care of residents with dementia, mental illness, cognitive impairments, mental retardation and other mental disabilities.
 - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
 - vi. Implementation of the initial assessment, annual assessment and support plan.
 - vii. Nutrition, food handling, and sanitation.
 - viii. Recreation, socialization, community resources, social services and activities in the community.
 - ix. Gerontology.
 - x. Staff person supervision, if applicable.
 - xi. Care and needs of residents with special emphasis on the residents being served in the home.
 - xii. Safety management and hazard prevention.
 - xiii. Universal precautions.
 - xiv. The requirements of this chapter.
 - xv. Infection control.
 - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers (bed sores), incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

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

- Direct care staff person A, hired [redacted] 16, was unsupervised while providing ADL care to resident #1 on 11/19/16. Direct care staff person A had not yet completed a demonstration of job duties followed by supervised practice.

3. Description of the Repair of the Immediate Problem:

Two other direct care staff as listed above reported an incident that occurred on Saturday evening, 11/19/16 at approximately 8:00 p.m. Staff person A, who was hired on [redacted] 16 and was working on the floor on her first day of supervised training. Staff person A responded to the call bell of Resident listed above at approximately 8:00pm. Resident requires physical assist x 1 for care, but is alert and oriented x 3. Staff person A completed care for Resident and exited the apt. after approximately 15 minutes. Staff person A then reported to two other direct care staff that the resident requested to get ready for bed and during the assist became upset and agitated. Upon hearing this information, and because it was contrary to the Resident's normal routine, the two other direct care staff followed up with Resident. Resident

Authorized Signature  Date: 1-9-17

1/19/17

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reported that staff person A was insistent that [redacted] get ready for bed and that felt like [redacted] was being forced to remove [redacted] clothes to get ready for bed. The resident also reported that [redacted] felt disrespected and fearful. Resident communicated that at no time was [redacted] physically harmed, but that [redacted] did feel [redacted] was being forced to get ready for bed, when this was not [redacted] request. The request was made for assistance to the bathroom, and the two other direct care staff did complete this care. Upon hearing this information, the two other direct care staff immediately reported the information regarding the incident as stated above to the Charge Nurse on duty. Charge Nurse made sure staff person A was directly supervised for remainder of shift and did not complete care alone and provided assist and support to all RCA's on duty. No further incidents were reported for remainder of assigned shifts (2 total). After being made aware of this incident on 11/21/16, the ED & DRCS immediately began an investigation. Interviews with all individuals listed above were conducted and written statements were obtained. [redacted] at OAPS was called to inform of incident, and guidance was requested as to whether an ACT 13 Report was required in this case. The ED & DRCS were informed by the OAPS Representative that an ACT 13 report was not needed. OAPS official provided instruction for us to offer Resident to speak to the Ombudsman and follow up with DHS reporting. After completing investigation, staff person A's employment was terminated. Charge Nurse involved in this incident to be immediately retrained on Resident Rights and reporting requirements. Documentation of training will be sent to DHS when completed and kept on file in the home. Family and physician were notified of incident.

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

- Staff education on Staff requirements and Mandatory training conducted by [redacted] Executive Director, and [redacted] Director of Resident Care Services, on 12/20/16 & 12/28/16 with all staff. See attached documentation.
- Director of Resident Care Services educated on the importance of completing attached Department Orientation prior to staff persons working the floor unsupervised as it relates to the regulation. See attached Department Orientation.
- The ED and Assistant ED will continue to monitor this training is completed consistently as part of the new hire orientation and training for new staff persons.

Within 30 days of receipt of the plan of correction: a designated staff person will review staff training records to ensure all direct care staff persons who provide unsupervised ADL services have completed all the requirements of regulation 2600.65d.

g.u. 1/19/17

Authorized Signature Gay D. [redacted]

Date: 1-9-17

g.u. 1/19/17