



pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: May 7, 2018

Ms. Rebecca Dale, RN, ED
Administrator
Tithonus Clearfield LP
6600 Brooktree Court, Ste. 1000
Wexford, Pennsylvania 15090

RE: Colonial Courtyard at Clearfield
1300 Leonard Street
Clearfield, Pennsylvania 16830
Certificate #: 447330

Dear Ms. Dale:

As a result of the Department of Human Services' licensing inspection on October 17, 2017 and October 18, 2017, of the above facility, the violations with 55 Pa.Code Ch. 2800 (relating to Assisted Living Residences) 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. 2800 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jon Kimberland".

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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APR 13 2018

WEST REGION FIELD OFFICE
Human Services Licensing

LICENSING INSPECTION SUMMARY
Assisted Living Residences – 55 Pa.Code § 2800

ALR Name: Colonial Courtyard at Clearfield	License Number: 447330
Address: 1300 Leonard St, Clearfield, PA 16830	County: Clearfield
Administrator: Rebecca Dale	
Legal Entity Name: Tithonis Clearfield LP	
Legal Entity Address: 6600 Brooktree Court, Suite 100, Wexford, PA 15090	
Certificate(s) of Occupancy: I-1 & I-2; 12/28/15; Lawrence Township	
Type of Inspection: Partial	
Reason(s) for Inspection(s): Incident Investigations	
On-Site Inspections Dates and Department Representatives On-Site: 10/17/17 and 10/18/17	
Off-Site Inspection Dates and Inspectors, if Applicable:	
Resident Demographic Data as of Inspection Dates	
Licensed Capacity: 74 Number of Residents Served: 49 Secured Dementia Care Unit in Home: yes Area: Life Stories Secured Unit Capacity, if Applicable: 17 Number of Residents Served in Secured Dementia Care Unit, if applicable: 15 Number of Current Hospice Residents: 2 Number of Hospice Residents in past year: 12	Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 49 Have Mental Illness: 1 Have an Intellectual Disability: 0 Have a Mobility Need: 21 Have a Physical Disability: 0

Rebecca Dale, Executive Director 4-13-18

APR 13 2018

WEST REGION FIELD OFFICE
Human Services Licensing

Regulation

2800.15(a) - The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adults Protective Services Act (35 P.S. §§ 10225.701 -10225.707) and 6 Pa. Code §§ 15.21 - 15.27 (relating to reporting suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.

Violation

On 10/5/17, at approximately 3:30 p.m., direct care staff person A was observed by direct care staff person B providing continence care to resident #1. During this care direct care staff person A crossed and held resident#1's arms in front of resident restricting the resident's ability to move his/her arms. After care was completed resident #1 struck staff person A on the head. Staff person A then grabbed the resident's wrists and loudly yelling at the resident, "You don't hit me. You'll never hit me".

This incident was not reported to the local Area Agency on Aging until 10/5/18 at 8:35 p.m.

Plan of Correction

See attached pages 1A and 1B of 3

Printed Name and Title of Legal Entity Representative (Required on all pages) *Rebecca Cole Executive Director*

Signature of Legal Entity Representative (Required on all pages) *Rebecca Cole Executive Director* Date *4-13-18*

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The above plan of correction is approved as of *4-16-18*
(Date)

Plan of correction implementation status as of *4-16-18*
(Date)

The above plan of correction was approved by *[Signature]*
(Initials)

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

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PLAN OF CORRECTION

Community Name: Colonial Courtyard at Clearfield

License Number: 447330

Date of Visit: 10/17/18 and 10/18/17

Date of Submission: 4/13/18

1. Violation Review: 2800.15 (a) The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adults Protective Services Act and 6 Pa. Code 15.21-15.27 (relating to suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.
2. Violation Interpretative Statement: On 10/5/17 at approximately 3:30pm, direct care staff person A was observed by direct care staff person B providing continence care to resident #1. During this care direct care staff person A crossed and held resident #1's arms in front of resident restricting the residents ability to move his/her arms. After care was completed resident #1 struck staff person A on the head. Staff person A then grabbed the resident's wrists and loudly yelled at the resident, "You don't hit me. You'll never hit me." The incident was not reported to the local Area Agency on Aging until 10/5/17 at 6:35pm.
3. Review the benefit of the Regulation, per RCG: Ensures that abuse or suspected abuse is appropriately reported and investigated.
4. Description of the Repair of the Immediate Problem: Once the Executive Director was made aware that the incident occurred, both direct care staff person A and B were immediately removed from the care area and separately interviewed. Direct care staff person B was ensured that coming forward was the right decision (although late). Direct care staff person A was immediately suspended pending the outcome of the investigation. Direct care staff person A was subsequently terminated from employment at the conclusion of the investigation on 10/11/17.
5. Determine / document the Root Cause of the Violation: Direct care staff person B, while she did report the incident, did not immediately report the incident.
6. Detail Action Steps / System Developed to prevent future occurrence: Direct care staff person B no longer is employed at the community for an unrelated cause. Direct care staff person A was terminated on 10-11-17 following the conclusion of the investigation. Community staff was re-trained on Preventing, Recognizing, and Reporting Abuse via Relias module in 2018. New team members since October 2017 received this training during General Orientation. The Director of

Authorized Signature Rebecca Dale Executive Director Date: 4-13-18

4-16-18

page 1

Resident Care or designee will perform an audit of reportable events weekly times 4 weeks between April and May 2018 to ensure adherence to the reporting policy consistent with the Adult Protective Services Act. Any reports not following reporting guidelines through the Adult Protective Services Act will be addressed with the individual involved in the erroneous reporting for education and follow-through, and additional reports made if necessary.

1. Violation Review: 2800.42 (c) – A resident shall be treated with dignity and respect.
2. Violation Interpretative Statement: On 10/5/17 at approximately 3:30pm, direct care staff person A was observed by direct care staff person B providing continence care to resident #1. During this care direct care staff person A crossed and held resident #1's arms in front of resident restricting the residents ability to move his/her arms. After care was completed resident #1 struck staff person A on the head. Staff person A then grabbed the resident's wrists and loudly yelled at the resident, "You don't hit me. You'll never hit me."
3. Review the benefit of the Regulation, per RCG: Ensures that residents are treated in a respectful and dignified manner.
4. Description of the Repair of the Immediate Problem: Both direct care staff person A and B were immediately removed from the care area and separately interviewed. Direct care staff person A was immediately suspended pending the outcome of the investigation. Direct care staff person A was subsequently terminated from employment at the conclusion of the investigation on 10/11/17.
5. Determine / document the Root Cause of the Violation: Staff person A, through physically restraining the resident during care, did not treat the resident in a respectful and dignified manner.
6. Detail Action Steps / System Developed to prevent future occurrence: Direct care staff person A was terminated on 10-11-17 following the conclusion of the investigation. Direct care staff person B no longer is employed at the community for an unrelated cause. Community staff was retrained on the prohibition of restraints in April 2018. Caregivers also signed new job descriptions in 2018 indicating respecting resident's rights. The Director of Resident Care Services or designee will audit three random resident care interactions with team members weekly times four weeks between April 2018 and May 2018 to ensure positive interventions and no use of restraints. Any negative findings will immediately be addressed with the involved parties and additional reports made as necessary.

Authorized Signature Rebecca Dale Executive Director Date: 9-13-18

Plan of Correction Template
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 or transmitted in any form or by any means, electronic, mechanical,
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WEST REGION FIELD OFFICE
 Human Services Licensing
 4-11-18

APR 13 2018

Regulation

2800.42(c) - A resident shall be treated with dignity and respect.

WEST REGION FIELD OFFICE
Human Services Licensing

Violation

On 10/5/17, at approximately 3:30 p.m., direct care staff person A was observed by direct care staff person B providing continence care to resident #1. During this care direct care staff person A crossed and held resident#1's arms in front of resident restricting the resident's ability to move his/her arms. After care was completed resident #1 struck staff person A on the head. Staff person A then grabbed the resident's wrists and loudly yelling at the resident, "You don't hit me. You'll never hit me".

Plan of Correction

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Rebecca Dale Executive Director

Signature of Legal Entity Representative (Required on all pages)

Rebecca Dale Executive Director

Date

4-13-18

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