



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**MAILING DATE: November 19, 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's Bureau of Human Services Licensing inspection on October 16, 2018 and October 17, 2018, 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 "Larry Mazza".

Larry Mazza  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

11/7/2018

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

Western Region Field Office  
 Bureau of Human Services Licensing

<b>Name of Assisted Living Residence:</b> Colonial Courtyard of Clearfield		<b>License Number:</b> 447330
<b>Address:</b> 1300 Leonard St, Clearfield PA 16830		<b>County:</b> Clearfield
<b>Administrator:</b> Rebecca Dale		
<b>Legal Entity Name:</b> Tithonus Clearfield LP		
<b>Legal Entity Address:</b> 6600 Brooktree Court, Ste 1000, Wexford PA 15090		
<b>Certificate(s) of Occupancy:</b> I-1 & I-2; 12/28/18; Lawrence Township		
<b>Type of inspection:</b> Partial		
<b>Reason(s) for inspection(s):</b> Complaints and Incident		
<b>On-Site Inspections Dates and Department Representatives On-Site:</b> 10/16/18 Duncan, Amy; Bartlett, Trish 10/17/18 Duncan, Amy; Bartlett, Trish		
<b>Off-Site Inspection Dates and Inspectors, if Applicable:</b>		
<b>Resident Demographic Data as of Inspection Dates</b>		
<b>Licensed Capacity:</b> 74	<b>Number of Residents who:</b>	
<b>Number of Residents Served:</b> 61	<b>Receive Supplemental Security Income:</b> 0	
<b>Secured Dementia Care Unit in Home:</b> yes	<b>Are 60 Years of Age or Older:</b> 61	
<b>Area:</b> Life Stories	<b>Have Mental Illness:</b> 1	
<b>Secured Unit Capacity, if Applicable:</b> 17	<b>Have an Intellectual Disability:</b> 0	
<b>Number of Residents Served in Secured Dementia Care Unit, if applicable:</b> 17	<b>Have a Mobility Need:</b> 24	
<b>Number of Current Hospice Residents:</b> 3	<b>Have a Physical Disability:</b> 0	
<b>Number of Hospice Residents in past year:</b> 10		

*Rebecca Dale*  
 Executive Director  
 11-7-18



# PLAN OF CORRECTION

**RECEIVED**

Community Name: Colonial Courtyard at Clearfield

11/7/2018

License Number: 447330

Western Region Field Office  
Bureau of Human Services Licensing

Date of Visit: 10/16/18 and 10/17/18

Date of Submission: 11/7/18

1. Violation Review: 2800.81 (b): Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair, and free of hazards.
2. Violation Interpretative Statement: Resident #2 had an unsecured bed enabler, which moved approximately 2" from side to side. Also, the enabler had an open area of approximately 12" X 18", posing an entrapment hazard.
3. Review the benefit of the Regulation, per RCG: Clean assistive devices that are in good repair are less likely to cause injury or illness to residents.
4. Description of the Repair of the Immediate Problem: The enabler was ratchet-strapped to the bedframe and the open area was covered with a cloth cover.
5. Determine / document the Root Cause of the Violation: While the enabler was clean and in good repair, the movement of the enabler and the open area present posed a potential entrapment hazard.
6. Detail Action Steps / System Developed to prevent future occurrence: Staff were retrained to be alert to movement and missing covers of bed enablers and to report this to their supervisor and/or Environmental Services Director. The Environmental Services Director will immediately check any enablers noted to be loose and re-secure as necessary. Staff will immediately replace any missing enabler covers.

Authorized Signature \_\_\_\_\_



Date: \_\_\_\_\_

11-7-18

Plan of Correction Template

ADM040

11/7/2018

LICENSING INSPECTION SUMMARY

Assisted Living Residences – 55 Pa.Code § 2800

Western Region Field Office  
Bureau of Human Services Licensing

<p><b>Regulation</b> 2800.203(b) - Half-length rails are permitted only if the following conditions are met: (1) The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.</p>
<p><b>Violation</b> On 10/17/18, a half-length bedrail was observed on resident #3's bed; however, resident 3's assessment and support plan, dated 1/15/18, does not address the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails. Also, the Residence's "bed side rails policy" indicates a half-length bed rail is permitted only if "a physician has completed an assessment within the past six (6) months and specified in writing that the use of the half-length rail is appropriate to protect the health and safety of the Resident. Resident Care team will complete a physical check of each Resident who uses a half-length bed rail at least every 15 minutes during the time when the bed rail is in use, and document the physical check". However, a physician did not assess the resident for use of a half-length bed rail and 15 minute checks were not completed.</p>
<p><b>Plan of Correction</b></p> <p style="text-align: center; font-size: 2em;">Please see attached</p> <p style="text-align: right;">See page 3A of 4</p>

Regulation

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

Signature of Legal Entity Representative (Required on all pages) Date *11-7-18*  
*Robina Wilk, ED*

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

<p>The above plan of correction is approved as of <u>11/8/18</u> (Date) <i>LN</i> The above plan of correction was approved by (Initials)</p>	<p>Plan of correction implementation status as of <u>11/8/18</u> (Date):</p> <ul style="list-style-type: none"> <li><input type="radio"/> Fully Implemented</li> <li><input checked="" type="radio"/> Partially Implemented – Adequate Progress <i>LN</i></li> <li><input type="radio"/> Partially Implemented – Inadequate Progress</li> <li><input type="radio"/> Not Implemented</li> </ul>
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- 1. Violation Review: 2800.203 (b): Half-length rails are permitted only if the following conditions are met:

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11/7/2018

Western Region Field Office  
Bureau of Human Services Licensing

- a. The resident's assessment or support plan, or both, addresses the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails.

- 2. Violation Interpretative Statement: On 10/17/18, a half-length bedrail was observed on resident #3's bed; however, resident 3's assessment and support plan, dated 1/15/18, does not address the medical symptoms necessitating the use of half-length rails and the health and safety protection necessary in order to safely use half-length rails. Also, the Residence's "bed side rails policy" indicates a half-length bed rail is permitted only if "a physician has completed an assessment within the past six (6) months and specified in writing that the use of the half-length rail is appropriate to protect the health and safety of the Resident. Resident Care Team will complete a physical check of each Resident who uses a half-length bed rail at least every 15 minutes during the time when the bed rail is in use, and document the physical check." However, a physician did not assess the resident for use of a half-length bed rail and 15 minute checks were not completed.

- 3. Review the benefit of the Regulation, per RCG: Protects residents from bedrail misuse.
- 4. Description of the Repair of the Immediate Problem: The half-length bed rail was immediately removed from the resident's bed. The resident does not use the bed but sleeps in her recliner.
- 5. Determine / document the Root Cause of the Violation: The rail was applied by the resident's son, without permission from the Community. Community employees failed to recognize the potential bed rail misuse since the resident did not use the bed.
- 6. Detail Action Steps / System Developed to prevent future occurrence: Staff were retrained on the type of allowable bed rails in the community and to alert supervisors and/or the Environmental Services Director if a non-allowable bed rail type is present. The Community will take immediate action if a non-allowable bed rail is present, by either removing the rail or by following policy through physician assessment, physical checks, and documentation.

Authorized Signature                     *Bebera Dore EO*                    

Date:           11-7-18

11/8/2018

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

Western Region Field Office  
Bureau of Human Services Licensing

2800.227(d) - Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

Violation

Resident #1 uses a bed enabler and a wedge during the night; however, this is not indicated on the resident's support plan, finalized on 8/30/18.

Resident #2 uses a bed enabler; however, this is not indicated on the resident's support plan, finalized on 8/10/18.

Plan of Correction

*Please see attached*

See page 4A of 4

Printed Name and Title of Legal Entity Representative (Required on all pages) *Roberta White Executive Director*  
Signature of Legal Entity Representative (Required on all pages) *Roberta White, ED* Date *11-7-18* revised *11-8-18*

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The above plan of correction is approved as of 11/8/18  
(Date)

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

Plan of correction implementation status as of 11/8/18  
(Date)

- Fully Implemented
- Partially Implemented – Adequate Progress *JN*
- Partially Implemented – Inadequate Progress
- Not Implemented

1. Violation Review: 2800.227 (d): Each residence shall document in the resident's final support plan the dietary, medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.
  2. Violation Interpretative Statement: Resident #1 uses a bed enabler and a wedge during the night; however, this is not indicated on the resident's support plan, finalized on 8/30/18. Resident #2 uses a bed enabler; however, this is not indicated on the resident's support plan, finalized on 8/10/18.
  3. Review the benefit of the Regulation, per RCG: Ensures that each resident's needs are met, and that accountability for meeting those needs is firmly established, prior to or shortly after admission to the community.
  4. Description of the Repair of the Immediate Problem: Resident #1's bed enabler and wedge were added to his support plan. Resident #2's bed enabler was added to her support plan.
  5. Determine / document the Root Cause of the Violation: The Director of Resident Care Services failed to add the resident's assistive devices to his support plan.
  6. Detail Action Steps / System Developed to prevent future occurrence: The Director of Resident Care was retrained on the necessity of adding supportive devices to the resident's support plan. The Director of Resident care will report on any additional assistive devices added to resident support plans monthly times three months at the Community's Quality Assurance meeting.
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Authorized Signature Rebecca Dale, DD Date: 11-8-18

Plan of Correction Template  
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ADM040

11/8/2018

Western Region Field Office  
Bureau of Human Services Licensing