



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MAILING DATE: March 13, 2019

Ms. Loriann Putzier
President & COO
Tithonus Clearfield LP
C/O Integracare Corporation
6600 Brooktree Court, Ste. 1000
Wexford, Pennsylvania 15090

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

Dear Ms. Putzier:

As a result of the Department's Bureau of Human Services Licensing inspection on November 20, 2018, of the above facility, the citations with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2800 must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Janine Wenzig".

Janine Wenzig
Human Services Licensing Supervisor

Enclosure
Violation Report

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

RECEIVED
 FEB 8 2019
 WEST REGION FIELD OFFICE
 Human Services Licensing

PCH Name: Colonial Courtyard at Clearfield		License Number: 447330
Address: 1300 Leonard Street, Clearfield, PA 16830		County: Clearfield
Administrator: Rebecca Dale		
Legal Entity Name: Tithonus Clearfield LP		
Legal Entity Address: 660 Brooktree Court, Ste. 1000, Wexford, PA 15090		
Certificate(s) of Occupancy: I-1, I-2, issued 12/28/15 by Lawrence Township		
Type of Inspection: Partial		
Reason(s) for Inspection(s): Incident		
On-Site Inspections Dates and Department Representatives On-Site: 11-20-18 McConnell, Debora		
Off-Site Inspection Dates and Inspectors, if Applicable: 11-21-18		
Resident Demographic Data as of Inspection Dates		
Licensed Capacity: 74 Number of Residents Served: 58 Secured Dementia Care Unit in Home: Yes Area: Memory Care Secured Unit Capacity, if Applicable: 17 Number of Residents Served in Secured Dementia Care Unit, if applicable: 17 Number of Current Hospice Residents: 3 Number of Hospice Residents in past year: 10		Number of Residents who: Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 58 Have Mental Illness: 2 Have an Intellectual Disability: 0 Have a Mobility Need: 24 Have a Physical Disability: 0

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

Regulation

§ 2800.15. Abuse reporting covered by law

(a) The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adult 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 11/10/18, at approximately 7:00 p.m., resident #1, who is a resident of the Special Care Unit, was being assisted in undressing for bed by multiple direct care staff persons, including staff person A. Minutes after the incident, staff person B received an allegation of abuse against staff person A, indicating that staff person A grabbed resident #1's wrists and held the resident's hands down in an attempt to restrain the resident. The home did not report the allegation of abuse regarding resident #1 to the local area agency on aging until 11/11/18, at 11:00 p.m.

Plan of Correction

see attached

Page 2A of 4

Printed Name and Title of Legal Entity Representative (Required on all pages)

Rebecca Dale, Executive Director

Signature of Legal Entity Representative (Required on all pages)

Rebecca Dale

Date

2-8-19

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

The above plan of correction is approved as of 2/26/19
 (Date)

Plan of correction implementation status as of 2/26/19
 (Date)

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

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

PLAN OF CORRECTION

Community Name: Colonial Courtyard at Clearfield

License Number: 447330

Date of Visit: November 20, 2018

Date of Submission: 2/8/19

1. Violation Review: 2800.15 Abuse Reporting Covered by law. (a) The residence shall immediately report suspected abuse of a resident served in the residence in accordance with the Older Adult Protective Services Act (35 P.S. 10225.701-10225.707) and 6Pa. Code 15.21-15.27 (relating to reporting suspected abuse, neglect, abandonment or exploitation) and comply with the requirements regarding restrictions on staff persons.
2. Violation Interpretative Statement: On 11/10/18 at approximately 7pm, resident #1, who is a resident of the Special Care Unit, was being assisted in undressing for bed by multiple direct care staff persons, including staff person A. Minutes after the incident, staff person B received an allegation of abuse against staff person A, indicating that staff person A grabbed resident #1's wrists and held the resident's hands down in an attempt to restrain the resident. The home did not report the allegation of abuse regarding resident #1 to the local area agency on aging until 11/11/18, at 11pm.
3. Review the benefit of the Regulation, per RCG: Primary benefit – ensures that abuse or suspected abuse is appropriately reported and investigated.
4. Description of the Repair of the Immediate Problem: Staff person B was formally counseled regarding abuse reporting requirements. Staff person B is no longer employed by the community.
5. Determine / document the Root Cause of the Violation: While the witness to the alleged abuse did report the incident to her supervisor on duty, her supervisor failed to immediately report the allegation to the Area Agency on Aging.
6. Detail Action Steps / System Developed to prevent future occurrence: Staff were educated on the community's policy on reporting suspected abuse, as well as PA 2800.42, Resident Rights. Notices have been placed in the staff areas of the community to remind staff of the immediate reporting requirements. Plans of correction for violations are reviewed for compliance at the community's monthly Quality Assurance meeting.

Authorized Signature

Rebecca Dale ED

Date:

2-8-19

Plan of Correction Template

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[Signature]

2/26/19

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

§ 2800.15. Abuse reporting covered by law

(b) If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Violation

On 11/10/18, at approximately 7:00 p.m., resident #1, who is a resident of the Special Care Unit, was being assisted in undressing for bed by multiple direct care staff persons, including staff person A. Minutes after the incident, staff person B received an allegation of abuse against staff person A, indicating that staff person A grabbed resident #1's wrists and held the resident's hands down in an attempt to restrain the resident. The home did not develop and implement a plan of supervision or suspend staff person until 11/12/18. Staff person A remained on duty till 11:00 p.m., on the date of the incident, providing direct care to residents, including resident #1.

Plan of Correction

See attached Page 3A of 4

Printed Name and Title of Legal Entity Representative (Required on all pages)

Rebecca Dale Executive Director

Signature of Legal Entity Representative (Required on all pages)

Rebecca Dale

Date

2-8-19

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The above plan of correction is approved as of 2/26/19
(Date)

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

Plan of correction implementation status as of 2/26/19
(Date)

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

1. Violation Review: 2800.15. Abuse reporting covered by law (b) If there is an allegation of abuse of a resident involving a residence's staff person, the residence shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.
 2. Violation Interpretative Statement: On 11/10/18 at approximately 7pm, resident #1, who is a resident of the Special Care Unit, was being assisted in undressing for bed by multiple direct care staff persons, including staff person A. Minutes after the incident, staff person B received an allegation of abuse against staff person A, indicating that staff person A grabbed resident #1's wrists and held the resident's hands down in an attempt to restrain the resident. The home did not develop and implement a plan of supervision or suspend staff person until 11/12/18. Staff person A remained on duty until 11pm, on the date of the incident, providing direct care to residents, including resident #1.
 3. Review the benefit of the Regulation, per RCG: Primary benefit – ensures that abuse or suspected abuse is appropriately reported and investigated.
 4. Description of the Repair of the Immediate Problem: Staff person A was suspended upon notification to the Executive Director that the allegation took place. Statements were obtained from involved parties and formal counseling was provided to staff person B who failed to report the incident timely.
 5. Determine / document the Root Cause of the Violation: Staff person B failed to recognize and report the alleged incident as potential abuse, therefore allowing the alleged perpetrator to continue to work and place resident #1 and other residents at potential risk.
 6. Detail Action Steps / System Developed to prevent future occurrence: Staff were educated on the community's policy on reporting suspected abuse, as well as PA 2800.42, Resident Rights. Notices have been placed in the staff areas of the community to remind staff of the immediate reporting requirements. Plans of correction for violations are reviewed for compliance at the community's monthly Quality Assurance meeting. Staff person A and staff person B are no longer employed at the community.
-

Authorized Signature

Rebecca Dale ED

Date:

2-8-19

Plan of Correction Template

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2/16/19

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

Regulation

§ 2800.84. Heat sources.

Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120° F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.

Violation

On 11/20/18, at 11:25 a.m., the temperature of the metal frame around the top of the gas fireplace measured 166.1 degrees Fahrenheit. There was no protective guard or insulation to prevent residents from coming in contact with the heat source.

Plan of Correction

See attached Page 4A of 4

Printed Name and Title of Legal Entity Representative (Required on all pages)

Rebecca Dale Executive Director

Signature of Legal Entity Representative (Required on all pages)

Rebecca Dale

Date

2-8-19

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

The above plan of correction is approved as of 2/26/19
(Date)

Plan of correction implementation status as of 2/16/19 :
(Date)

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

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

1. Violation Review: 2800.84 Heat Sources. Heat sources, such as steam and hot heating pipes, water pipes, fixed space heaters, hot water heaters and radiators exceeding 120 degrees F that are accessible to the resident must be equipped with protective guards or insulation to prevent the resident from coming in contact with the heat source.
 2. Violation Interpretative Statement: On 11/20/18 at 11:25am, the temperature of the metal frame around the top of the gas fireplace measured 166.1 degrees Fahrenheit. There was no protective guard or insulation to prevent residents from coming in contact with the heat source.
 3. Review the benefit of the Regulation, per RCG: Minimizes the risk that residents will suffer burns by coming into contact with exposed heat sources.
 4. Description of the Repair of the Immediate Problem: The gas fireplace was immediately turned off and signage placed on top of the control unit to not turn on the fireplace. A notice was placed in the community to alert residents, team members, and visitors of the need to have the fireplace remain off until a protective guard could be placed.
 5. Determine / document the Root Cause of the Violation: The gas fireplace lacked a protective guard to minimize the risk of a resident coming in contact with the heat source.
 6. Detail Action Steps / System Developed to prevent future occurrence: A protective guard that spans the length and width of the fireplace has been ordered. Until such time as it is received and installed, the fireplace remains off and signage remains posted as to the reasoning.
-

Authorized Signature Rebecca Dale ED

Date: 2-8-19



2/26/19