



SENT VIA EMAIL: lgrant@integracare.com
lputzier@integracare.com

MAILING DATE: May 4, 2020

Ms. Loriann Putzier
President & COO
Tithonus Greensburg, LP
C/O Integracare Corporation
6600 Brooktree Court, Suite 100
Wexford, Pennsylvania 15090

RE: Newhaven Court at Lindwood
100 Freedom Way
Greensburg, Pennsylvania 15601
License #: 429360

Dear Ms. Putzier:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on January 10, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *NEWHAVEN COURT AT LINDWOOD*

License Number: *42936*

Address: *100 FREEDOM WAY,, GREENSBURG, PA 15601*

County: *WESTMORELAND*

Region: *WESTERN*

Administrator

Name: *LORI GRANT*

Phone: *7248532502*

Email: *LPUTZIER@INTEGRACARE.COM*

Legal Entity

Name: *TITHONUS GREENSBURG LP*

Address: *6600 BROOKTREE COURT,SUITE 1000, C/O INTEGRACARE CORP, WEXFORD, PA, 15090*

Certificate(s) of Occupancy

Type: *C-2 LP*

Date:

Issued By:

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *134*

Waking Staff: *101*

Inspection

Type: *Partial*

BHA Docket #:

Notice: *Unannounced*

Reason: *Complaint,Incident*

Inspection Dates and Department Representative

01/10/2020 - On-Site: Jan Cutter

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *128*

Residents Served: *101*

Secured Dementia Care Unit

In Home: *Yes*

Area:

Capacity: *16*

Residents Served: *14*

Forest Hills Neighborhood

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *101*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *33*

Have Physical Disability: *0*

42c - Treatment of Residents

Regulations

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 1/3/2020 at approximately 1:50 pm, resident #1 was sitting in her wheelchair in the doorway of her apartment starting to come out of her room. Direct care staff A stood in front of resident #1's chair, put her hands on the armrest and shoved it backwards into the resident's room while stating in an aggressive voice "Get in there".

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.)

Please see attached

See pages 2a and 2b of 2

Legal Entity Representative

[Handwritten Signature]
Signature

Lori Grant, Executive Operations Officer 4/18/2020
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 4/30/20
(Date)

Plan of correction implementation status as of 4/30/20
(Date)

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

Implemented
 Not Implemented

Community Name: Newhaven Court at Lindwood

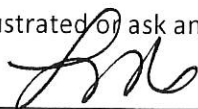
License Number: 429360

Date of Visit: January 10, 2020

Date of Submission: April 9, 2020

1. **Violation Review:** 2600.42.c A Resident shall be treated with dignity and respect.
2. **Violation Interpretative Statement:** On January 3, 2020, at approximately 1:50 pm, resident #1 was sitting in her wheelchair in the doorway of her apartment starting to come out of her room. Direct care staff A stood in front of resident #1's chair, put her hands on the armrest and shoved it backwards into the resident's room while stating in an aggressive voice "Get in there."
3. **Review the benefit of the Regulation, per RCG:** The benefit of this regulation is to ensure that all Residents are treated with dignity and respect at all times while residing in personal care home communities. Staff are trained on this regulation and instructed to immediately report any concerns or situations, that do not resonate with them well, to the Area on Aging and/or the Executive Operations Officer/designee. Staff are reminded of this regulation often and trained multiple times throughout a calendar year as a refresher.
4. **Description of the Repair of the Immediate Problem:** The staff person, who reported the incident, immediately followed the protocol for regulation 2600.42.c. Staff are to immediately report any concerns or situations that may arise in the home immediately to the Area on Aging, or if uncomfortable reporting the circumstance, to the Executive Operations Officer/designee so that call can be made. After witnessing Staff Member A's actions with Resident #1, the witness immediately, without hesitation, reported the circumstance. Staff Member A was immediately sent home pending the investigation and removed from the schedule. After immediately removing Staff Member A from the community, at the same time, the circumstance was immediately reported to the Area on Aging and then to the Department of Human Services. Statements were obtained from Staff Member A and the witness for review. After reviewing both statements, Staff Member A's employment with Newhaven Court at Lindwood was immediately terminated due to the actions/behavior witnessed. The witness followed all policies and protocols. Resident #1 was not harmed, injured or hurt. Resident #1 did not communicate/show any mental anguish or upset emotions regarding this circumstance .
5. **Determine / document the Root Cause of the Violation:** Staff Member A became frustrated with Resident #1, since the Resident was allegedly giving Staff Member A a difficult time, instead of safely walking away from the situation or asking for another staff person to take over, Staff Member A allowed their emotions to take over. Staff are trained to walk away (if the situation is safe for the Resident first and foremost) before they become frustrated or ask another staff person to take over.

Authorized Signature _____



Date: _____

4/13/2020

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6. Detail Action Steps / System Developed to prevent future occurrence:

- a. **Changing practice?** Staff were re-educated on January 3, 2020, on our systems and processes when it comes to Resident Rights and Resident Abuse. The witness, and the home, did exactly what they have been trained to do such as reporting the allegation immediately to the Area on Aging and the Department of Human services as well as removing Staff Person A immediately from the schedule/home. Staff Person A was terminated from Newhaven Court at Lindwood.
- b. **Teaching or Training?** All staff were re-educated on January 3, 2020, on Resident Abuse and Resident Right regulations and protocols.
- c. **On-going Monitoring?** The witness to this situation did exactly what they have been trained to do per our regulations and policies. They reported the incident immediately for investigation. The home did exactly what the regulation states, which is to immediately report to the Area on Aging and the Department of Human Services as well as immediately suspend the perpetrator pending the investigation.

7. Designated position responsible and specify target date for correction.

All staff were re-educated on this regulation and policy on January 3, 2020. Please see attached training which includes training materials and record of trainings for review. All staff are responsible and obligated to report circumstances that are of concern or discomfort immediately to the Area on Aging for investigation.

Authorized Signature _____



Date: _____

4/18/2020