Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

June 2, 2023

TITHONUS TYRONE LP

RE: COLONIAL COURTYARD AT TYRONE
5546 EAST PLEASANT VALLEY BLVD
TYRONE, PA, 16686
LICENSE/COC#: 32949

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/09/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *COLONIAL COURTYARD AT TYRONE* **Licen e #**: *32949* **Licen e Expiration**: *08/15/2023*

Address: *5546 EAST PLEASANT VALLEY BLVD, TYRONE, PA 16686*

County: *BLAIR* **Region**: *CENTRAL*

Administrator

Name: **Phone** **Email**:

Legal Entity

Name: *TITHONUS TYRONE LP*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C 2 LP* **Date**: *03/02/1999* **I ued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint* **Exit Conference Date**: *03/09/2023*

Inspection Dates and Department Representative

03/09/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *70* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *11* **Residents Served**: *7*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older**: *36*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *10* **Have Physical Disability**: *0*

Inspections / Reviews

03/09/2023 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2023*

04/07/2023 - POC Submission

Submitted By: **Date Submitted**: *04/26/2023*
Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/14/2023*

Inspections / Reviews *(continued)*

04/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/26/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/27/2023*

06/02/2023 - Document Submission

Submitted By [redacted] **Date Submitted:** *04/26/2023*

Reviewer [redacted] **Follow-Up Type:** *Not Required*

16c - Written Incident Report

1. Requirements

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 § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted] 2021, a medication error occurred involving Staff Member A. An incident report was not submitted to the Department.

Repeated Violation - 1/26/22

Plan of Correction ***Accept ([redacted] - 04/20/2023)***

On 3/16/2023, Resident Wellness Director (RWD) completed a reeducation of the wellness & dietary staff of what is to be reported on an Incident Report as well as the required timing of reporting to their department Director. Directors are to immediately report any incidents to RWD or EOO who will then complete an investigation & report findings to DHS within the required 24 hours. EOO or designee will review reportable incidents within 24 hours of the report. Medication Associates (MA) were reeducated on the proper steps of medication administration, storage & disposal of medications. Beginning 3/20/2023, Resident Wellness Director will perform cart audits & random polling of medication administration staff to ensure knowledge and compliance. These audits will be performed 2 times per week for 3 months and then monthly basis to ensure no deficiencies are found. Reeducation will be conducted with any MA staff who are noncompliant.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented ([redacted] - 05/19/2023)

42p - Restraints

2. Requirements

2600.
42.p. A resident shall be free from restraints.

Description of Violation

Resident 1 reports that he/she does not receive assistance with transferring out of bed because staff state, "you can't get up, you'll fall." Resident 1 states that he/she wants to participate in activities and be social but is not permitted to do so. Staff Member E confirmed that the home's management instructed staff not to assist Resident 1 with getting out of bed due to the fall risk.

Plan of Correction ***Accept ([redacted] - 04/20/2023)***

On 3/10/2023, EOO began an internal investigation regarding the allegation. Blair County Adult Protective Services were notified of the allegation on 3/10/2023. The EOO's internal investigation was completed on 3/12/2023 and BCAPS completed their investigation as unsubstantiated on 3/24/2023. On 3/16/2023 RWD reeducated wellness staff and direct care staff on Resident Rights, specifically, that residents are not be denied help and accessibility to community activities or assistance leaving their room. To ensure no resident is denied help, direct care staff will report to the RWD or designee any situation when a resident refuses assistance or decline to leave their room. This will ensure accountability and show a record of not confining residents to their room if allegations should arise.

Licensee's Proposed Overall Completion Date: *04/28/2023*

42p - Restraints *(continued)*

Implemented (SK - 05/19/2023)

65a - FS Orientation 1st Day

3. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member B, hired 22, did not receive required training on the following topics:

- *Evacuation procedures*
- *Staff duties during fire drills, emergency evacuation and transportation*
- *Designated meeting places and/or fire safe zones*
- *Smoking safety procedures and smoking areas*
- *Location of fire extinguishers and their use*
- *Smoke detectors and fire alarms*
- *Use of telephone and notifying emergency services*

Plan of Correction ***Accept (- 04/20/2023)***

A complete audit of current staff personnel files was completed on 3/24/2023 by the Administrative Services Director to ensure documentation is complete & accurate. Moving forward, after 1st day education of fire safety training by the Safety and Maintenance Engineer is completed, Administrator and or Designee will check all new hire paperwork filed in employee's file is accurate and documented correctly to show training was completed on 1st day.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Members A, B, C and D did not receive required training in Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. 1022.101-10225.5102) or Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours (continued)

Plan of Correction ***Accept (- 04/20/2023)***

A complete audit of current staff personnel files was completed on 3/24/2023 by the Administrative Services Director to ensure documentation is complete & accurate. To ensure compliance in the future, after 1st day education of Reporting Abuse and Neglect under the
Older Adult Protective Services Act and Reporting of Reportable incidents and conditions, Administrator and or Designee will check all new hire paperwork filed in employee's file is accurate and documented correctly to show training was completed on 1st day.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)

66a - Staff Training Plan

5. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

An annual staff training plan for 2023 has not been developed for the home.

Plan of Correction ***Accept (- 04/20/2023)***

On 3/13/2023, Administrator secured the Annual Staff Training Plan which had be previously provided by ICC Corp Office. To ensure this violation does not occur again, Administrator has set a calendar reminder to reach out to ICC Corp Office requesting the training plan be provided to EOO or designee no later than 12/20 each year to ensure PCH is not out of compliance.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)

109b - Rabies Vaccination

6. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 3/09/23, Resident 2's pet canine, named "Cinnamon," was last given a 3-year rabies vaccination on -2020, however, the vaccination expired on -2023.

Plan of Correction ***Directed (- 04/20/2023)***

Life Stages Director will set reminders in calendar of when Rabies Vaccinations will be due one month prior to expiration. Life stages Director will inform and remind residents and their family and/or contact person that their pet will need to be revaccinated before the expiration date and assist residents if needed to set up appointments for pets

Directed:

109b - Rabies Vaccination (continued)

by 04/27/2023, Life Stages Director will set reminders in calendar of when Rabies Vaccinations will be due one month prior to expiration. Life stages Director will inform and remind residents and their family and/or contact person that their pet will need to be revaccinated before the expiration date and assist residents if needed to set up appointments for pets.

Directed Completion Date: *04/27/2023*

Implemented (- 05/19/2023)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 3's Documentation of Medical Evaluation (DME) from 2022, does not include the resident's blood pressure, height, weight, pulse rate and temperature from their physical examination.

Plan of Correction ***Accept (- 04/20/2023)***

On 3/10/2/2023, Resident Wellness Director reeducated by Administrator on proper completion of DMEs. To ensure all DMEs are correct, 24 hours prior to any new admissions, DME's will be reviewed by the Resident Wellness Director (RWD). If RWD discovers any discrepancies or missing information, RWD will contact the Physician to have them complete the form and fill in all required information. Effective immediately, Administrator or Corporate Compliance Nurse will review all new admission charts within 48 hours of admission to ensure all information is complete.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/02/2023)

187a - Medication Record

8. Requirements

2600.

187a - Medication Record *(continued)*

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident 4 has a prescription of [redacted] 2x daily, however there are no specific diagnoses listed for the order on the medication administration record (MAR).

Resident 5 has a prescription of [redacted] 1x daily and a [redacted] However, there are no diagnoses listed for either order on the resident's MAR.

Plan of Correction ***Accept ([redacted] 04/20/2023)***

On 3/16/2023 Administrator & RWD completed training and reeducation with wellness staff was to cover the expectations of regulation 187a and medication records. Beginning 3/17/2023, RWD or designee have completed daily audits of physician orders to ensure all information is correct and complete. These daily audits will be ongoing

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented ([redacted] - 05/19/2023)

187d - Follow Prescriber's Orders

9. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On [redacted]/2023 and [redacted]/2023 at [redacted] PM, Resident 5's blood glucose levels were [redacted] and [redacted] respectively. Per physician's orders, the home is supposed to call the Provider/Physician for any level over 449. There was no documentation provided that the home's staff called the physician to report these high blood glucose levels.

On [redacted] 2023 at 6:30 AM, Resident 5's blood glucose level was [redacted] which requires 14 units to be given, however the resident was only given 8 units, as insufficient medication was on hand or available in the home.

Plan of Correction ***Accept ([redacted] 04/20/2023)***

On 3/16/2023 RWD completed training and reeducation with wellness staff and covered the expectations of regulation 187d and medication policy and procedure and following prescriber's orders. On 3/17/2023 an auditing system was implemented to ensure all medication associates are following policy and procedures. Resident Wellness Director will perform MAR and cart audits as well as random polling of medication administration staff to ensure knowledge and compliance. These audits will be performed 2 times per week for 3 months and then monthly basis

187d - Follow Prescriber's Orders (continued)

to ensure no deficiencies are found. Retraining will be conducted with any MA staff who are noncompliant.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)

224a - Preadmission Screen Form

10. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 3's preadmission screening does not include the date that the form was completed, the screening information sources, primary language spoken, reason for leaving current residence or a determination that the needs of the resident can be met by the services provided by the home.

Resident 4's preadmission screening, dated /2022, does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction ***Accept (- 04/20/2023)***

On 3/10/2023 RWD was reeducated by EOO and Corporate Compliance Nurse on the Preadmission Screening process as well as the requirements for resident medical evaluations and health care requirements to ensure resident needs can be met. An auditing system was put into place on 3/20/2023 assigning RWD to review all new medical charts prior to resident admission with EOO completing audits within 48 hours of admission.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 06/02/2023)

227e - Self Administer Medication

11. Requirements

2600.
227.e. The resident's support plan must document the ability of the resident to self-administer medications or the need for medication reminders or medication administration.

Description of Violation

Resident 2's Resident Assessment-Support Plan (RASP), dated 2022, and the current medication administration record (MAR), both indicate that the resident is able to self-administer their medications. However the resident's Documentation of Medical Evaluation (DME), dated /2022, states that the resident is not able to self-administer their medication. The resident keeps an locked in their room or on their person.

227e - Self Administer Medication *(continued)*

Plan of Correction ***Accept (SK 04/20/2023)***

Resident's DME was updated on 3/23/2023. On 3/10/2/2023, Resident Wellness Director reeducated by Administrator on proper completion of DMEs. To ensure all DMEs are correct, 24 hours prior to any new admissions, DME's will be reviewed by the RWD. If RWD discovers any discrepancies or missing information, RWD will contact the Physician to have them complete the form and fill in all required information. Beginning 3/20/2023, RWD or designee will perform MAR/cart audits and random polling of medication administration staff to ensure knowledge and compliance. These audits will be performed 2 times per week for 3 months and then monthly basis to ensure no deficiencies are found. Retraining will be conducted with any MA staff who are noncompliant.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)

231c - Preadmission Screening

12. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department s preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 3 is a resident in the home's secure dementia care unit (SDCU). The resident's undated preadmission screening form does not include the required Cognitive Screening, to be completed by a physician or geriatric assessment team prior to admission to the SDCU.

Plan of Correction ***Accept (04/20/2023)***

On 3/10/2023 RWD was reeducated by EOO and Corporate Compliance Nurse on the Preadmission Screening process to ensure resident needs can be met. An auditing system was implemented on 3/20/2023 assigning RWD to review all new medical charts prior to resident admission with EOO completing audits within 48 hours of admission. EOO is currently conducting audits of existing SDCU residents projected completion date of 4/28/2023. Coordination with family of Resident 3 to complete the Objection Statement and completing all chart updates to reflect his transfer to SDCU will be completed by 4/28/2023.

Licensee's Proposed Overall Completion Date: *04/28/2023*

Implemented (- 05/19/2023)