

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

September 26, 2023

[REDACTED]
TITHONUS GREENSBURG LP

[REDACTED]
C/O INTEGRACARE CORP
[REDACTED]

RE: NEWHAVEN COURT AT LINDWOOD
100 FREEDOM WAY
GREENSBURG, PA, 15601
LICENSE/COC#: 42936

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/25/2023 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,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *NEWHAVEN COURT AT LINDWOOD* License #: *42936* License Expiration: *06/10/2024*
 Address: *100 FREEDOM WAY, GREENSBURG, PA 15601*
 County: *WESTMORELAND* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *TITHONUS GREENSBURG LP*
 Address: [REDACTED], *C/O INTEGRACARE CORP,* [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/02/2006* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *131* Waking Staff: *98*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *08/25/2023*

Inspection Dates and Department Representative

08/25/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *131* Residents Served: *95*
Secured Dementia Care Unit
 In Home: *Yes* Area: *Forest Hills* Capacity: *19* Residents Served: *18*
Hospice
 Current Residents: *6*
Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *95*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *36* Have Physical Disability: *0*

Inspections / Reviews

08/25/2023 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/27/2023*

09/21/2023 - POC Submission

Submitted By: [REDACTED] Date Submitted: *09/25/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *09/27/2023*

Inspections / Reviews *(continued)*

09/25/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 09/29/2023

09/26/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

225c - Additional Assessment

1. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #1's most recent assessment, dated [REDACTED]/22, does not include resident #1's new diagnoses of vascular dementia with violent and aggressive behaviors with paranoia and hallucinations as indicated in resident #1's physician progress note, dated [REDACTED] 23. Also, resident #1's assessment indicates no problems with aggression, judgment, agitation and irritability. Additionally, resident #1 was placed on 15 minute checks around [REDACTED] 23 due to resident #1's increase in behaviors and hallucinations; however, the 15 minute checks are not indicated on resident #1's assessment and resident #1's assessment indicates the resident has no supervision needs in our out of the home.

Plan of Correction

Accept [REDACTED] - 09/25/2023)

Determine / document the Root Cause of the Violation: Due to Resident #1's escalating behaviors in the home, the home's focus was the safety of the Residents, the safety of the employees, and Resident #1. Unfortunately, a new RASP reflecting a significant change did not occur per the regulation. Resident #1 did have a current RASP in place; however, it did not reflect the significant changes such as new diagnoses, escalating behaviors, and 15-minute checks.

Description of the Repair of the Immediate Problem: Resident #1 no longer resides in our community and an immediate repair to the problem was unable to occur.

Changing practice: Regulation 2600.225.c is already existing and in place in the home and is the responsibility of the Resident Wellness Director (RWD). Per the home's existing procedures, a RASP that requires a significant change will be completed if a Resident has a new diagnosis, change in mobility needs, change in program, significant improvement of a condition or a decline in condition, admission or discharge to hospice or has been out of the facility for 30 days or more. In regard to RASP updates and the home's procedures, if a Resident has minor updates such as glasses, hearing aides, or a walker, the Resident Wellness Director will document the minor updates on the RASP and initial so that the RASP reflects these minor changes. For Resident #1, a RASP reflecting a significant change should have been completed by the home due to their new diagnoses of vascular dementia, violent and aggressive behaviors with paranoia, hallucinations, and the need for 15-minute checks.

Teaching or Training: Regulation 2600.225.c is already in place in the home; however, Resident #1's RASP was missed due to focusing on the safety of the home, Residents, employees, and Resident #1. The Resident Wellness Director was re-educated on regulation 2600.225c and the home's existing procedures by the Executive Operations Officer on August 25th, 2023, in regard to RASP updates and significant changes as well as when either one needs to be completed. Please see attached training. Due to Resident #1 needing a RASP reflecting a significant change versus an updated RASP, on August 25, 2023, the Executive Operations Officer audited random charts on Residents, who most recently had a significant change such as a new diagnosis, change in mobility need, significant improvement of condition or a decline in condition, change in program, admission or discharge to hospice. During the audit, the RASPs were found to be in compliance with the regulation (please see attached RASPs that have had a significant change for verification).

225c - Additional Assessment (continued)

On-going Monitoring: The Charge Personnel will continue to review for changes and updates, daily, and on each shift. The RWD will continue to monitor and review for changes during normal business hours/operation. If the change lasts for more than 24 hours, the RWD will ensure the RASPs reflect updates or will complete a significant change if applicable from reviewing the communication log, shift change, quarterly assessments, re-assessment, discharge paperwork from a hospital/SNF, and from Charge Personnel within 5 days. Effective immediately and moving forward, and when applicable, when the RWD learns that a RASP needs to reflect a significant change or that updates are needed on the RASP, the RWD will complete the changes within 5 days if the change lasts for more than 24 hours. When the RWD completes a RASP reflecting a significant change or update, the RWD will give the completed RASP to the Executive Operations Officer for final review to ensure all changes are documented.

Designated position responsible and specify target date for correction: The Resident Wellness Director is responsible for all annual RASPs, RASP updates, and RASPs that require a significant change with oversight from the Executive Operations Officer. Please see attached RASPs to verify that compliance is being met in regard to significant changes.

Licensee's Proposed Overall Completion Date: 09/22/2023

Implemented [redacted] - 09/26/2023)

228b - Discharge or Transfer

2. Requirements

2600.

228.b. If the home initiates a discharge or transfer of a resident, or if the legal entity chooses to close the home, the home shall provide a 30-day advance written notice to the resident, the resident's designated person and the referral agent citing the reasons for the discharge or transfer. This shall be stipulated in the resident-home contract. A 30-day advance written notice is not required if a delay in discharge or transfer would jeopardize the health, safety or well-being of the resident or others in the home, as certified by a physician or the Department. This may occur when the resident needs psychiatric or long-term care or is abused in the home, or the Department initiates closure of the home.

Description of Violation

On [redacted]/23, resident #1 was discharged from the home due to home's inability to meet resident #1's current care needs; however, no 30-day advance written notice was provided to resident #1 or resident #1's designated person. There was also no documentation from resident #1's physician indicating a delay in the discharge of resident #1 would jeopardize the health, safety or well being of resident #1 or others in the home.

Plan of Correction

Accept [redacted] - 09/25/2023)

Description of the Repair of the Immediate Problem: Resident #1 no longer resides in our community in which immediate action was unable to be completed.

Determine / document the Root Cause of the Violation:

228b - Discharge or Transfer (continued)

On [REDACTED] 2023, Resident #1 and the POA were made aware of a 30-day notice that was being issued by the community due to Resident #1's behavior that was not resolving with medical and safety interventions. However, Resident #1's behavior quickly escalated in which they became a serious danger to their self and others. All medical and safety interventions continued to fail before the 30-day notice was written and issued to the Resident and POA. On [REDACTED], 2023, Resident #1's medical team, and the Resident Wellness Director, had a call/meeting with the POA to communicate that Resident #1's behaviors were escalating and was a danger to their self and others in the community. Therefore, immediate placement was necessary to keep Resident #1, and the community, safe. Resident #1 was also made aware of the community's concern as well. On [REDACTED], 2023, the Executive Operations Officer also had a conversation with Resident #1 and the POA about the need to terminate the agreement to do the Resident being a danger to their self and others. Therefore, alternative placement needed to happen as soon as possible in place of a 30-day notice as originally communicated. Per our contractual agreement on page 13 (14.1), "The Community may terminate this Agreement and Resident's stay, and transfer or discharge if Resident is a danger to [REDACTED] or other Residents, and the safety or health of Resident or other individuals in the Community is or otherwise would be endangered by the continued stay of Resident." The physician documented in Resident #1's chart: "I am concerned about escalating behaviors and aggression – may be a risk to staff. Monitor closely." However, the physician did not document, sign, and date in the chart "the delay in discharge or transfer would jeopardize the health, safety and well-being of the resident or others" per the regulation.

Changing practice: The home's usual procedure for a community initiated 30-day notice is already in place. If the home needs to initiate a 30-day notice, the home will first have a discussion with the Resident and Responsible party to discuss the concern(s). If the concern continues, a warning letter will be sent outlining the concern(s), should the concern occur again, a 30-day notice will be issued with approval from home office. If it is decided by the physician that the Resident's delay in transfer will jeopardize the Resident or others in the home, the physician will document in the chart (with a date and signature), "the delay in discharge or transfer would jeopardize the health, safety and well-being of the resident or others" prior to the discharge.

Teaching or Training? The Executive Operations Officer was educated about regulation 2600.228.b to ensure the clause is written in the chart by the physician (as well as dated and signed) before the discharge occurs on August 25th, 2023. Please see attached documentation. Effective immediately and moving forward, if a physician feels that a delay in transfer will jeopardize others in the home or the Resident, the Executive Operations Officer will ensure the physician documents, dates, and signs in the Resident's chart "the delay in discharge or transfer would jeopardize the health, safety and well-being of the resident or others." The General Area Manager will be a second check to ensure the clause is present in the Resident's chart prior to the discharge occurring.

On-going Monitoring: The home has not experienced a situation in which a 30-day community-initiated notice needed to be expedited per the physician due to the safety of the Resident or others in the home. Effective immediately and moving forward, the Executive Operations Officer will continue to be responsible and will follow the home's rules regarding a 30-day community-initiated discharge notice if applicable/as needed with permission from home office. However, if the physician feels that a delay in the discharge or transfer would jeopardize the health, safety, and well-being of the resident or others, the Executive Operations Officer will ensure that the physician documents the clause in the Resident's record before the discharge occurs. The General Area Manager will be a second check to ensure the clause is present in the Resident's chart prior to the discharge occurring.

Licensee's Proposed Overall Completion Date: 09/22/2023

228b - Discharge or Transfer *(continued)*

Implemented (LM - 09/26/2023)