



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Emailing Date: December 26, 2024

[REDACTED]
Tithonus Butler LP
[REDACTED]
[REDACTED]

RE: Newhaven Court at Clearview
License #: 42346

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department), licensing inspections on July 27, 2024, and October 16, 2024, and the corrections you have made after our inspection, we have found the above facility to be in compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes). Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

A handwritten signature in cursive script that reads "Juliet Marsala".

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosures
License
Licensing Inspection Summary

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

Facility Information

Name: *NEWHAVEN COURT AT CLEARVIEW* License #: *42346* License Expiration: *10/23/2024*
Address: *100 NEWHAVEN LANE, BUTLER, PA 16001*
County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *TITHONUS BUTLER LP*
Address: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *05/05/1996* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *122* Waking Staff: *92*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *07/25/2024*

Inspection Dates and Department Representative

07/25/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* Residents Served: *86*

Secured Dementia Care Unit

In Home: *Yes* Area: *Life Stories* Capacity: *18* Residents Served: *17*

Hospice

Current Residents: *12*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *85*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *36* Have Physical Disability: *0*

Inspections / Reviews

07/25/2024 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *08/24/2024*

Inspections / Reviews (*continued*)

08/26/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/04/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 09/03/2024

09/20/2024 - POC Submission

Submitted By: [REDACTED]

[REDACTED] [REDACTED] [REDACTED]

[REDACTED] [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 10/30/2024

12/05/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/04/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

65f - Training Topics

1. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
- 6. Safe management techniques.

Description of Violation

Direct care staff A, hired [REDACTED]/22, did not complete training in; Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan and safe management techniques during the January 2023 to December 2023 training year.

Direct care staff B, hired [REDACTED] 21, did not complete training in; Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan and safe management techniques during the January 2023 to December 2023 training year.

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

- 1. EOO had verbal communication with Area General Manager on 7/29/2024 to inform non-compliance of 2023 Training Curriculum.
- 2. EOO made AGM aware of non-compliance via email on 9/17/2024 and requested elevation to Regional Level for review of regulations regarding team member training for 2025 Training Year.

Preventative Action:

- 1. Community team members will be provided with education related to Regulation - 65.f. Training topics for the annual training for direct care staff persons shall include the following:
 - Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
 - Safe management techniques.
- 2. Executive Operations Officer will complete training with staff on 9/24/2024.

Corrective Action:

- 1. Executive Operations Officer to communicate regulatory concern with Regional Team for Newhaven Court at Clearview by 9/30/2024.
- 2. Training for 2025 Training Year will be created per company procedure by Regional Team. EOO will review curriculum for requirements and principals listed in regulations by 12/31/2024.

Licensee's Proposed Overall Completion Date: 12/01/2024

Implemented [REDACTED] - 12/04/2024)

65g - Annual Training Content

2. Requirements

2600.

65g - Annual Training Content (continued)

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Direct care staff B, hired [REDACTED] 21, did not complete training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. during the January 2023 to December 2023 training year.

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

1. Administrative Services Director will complete audit of current team members to verify compliance with Annual Fire Safety Training for training year 2023 by 9/30/2024.
2. Team members who did not receive Annual Fire Safety Training for training year 2023 will complete training with Safety and Maintenance Engineer by 10/15/2024.

Preventative Action:

1. Community staff will be educated on Regulation - 65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
2. Training will be completed by Executive Operations Officer and Safety and Maintenance Engineer on 9/24/2024.
3. Administrative Services Director will add Fire Safety Training to community Training Tracker effective 10/15/2024.

Corrective Action:

1. Current Team Members will attend mandatory Fire Safety Training to be conducted by Fire Safety Expert/Safety Maintenance Engineer that will be scheduled by EOO for all team Quarterly Meeting. 2024 Fire Safety Training to be completed by 11/15/2024.
2. Audit of team members who attended training will be conducted immediately following training by Administrative Services Director. Training information will be added to tracker by ASD.
3. Team members absent from training will be required to meet with SME individually by 11/30/2024 to complete required training.
4. Administrative Services Director will maintain training tracker and audit quarterly to verify compliance and plan for annual trainings/recertifications quarterly. Audit will be verified by ASD initials with date/time audit was completed.
5. EOO will review training tracker quarterly for compliance and completeness. Audit will be verified by EOO initials with date/time audit was completed.

Licensee's Proposed Overall Completion Date: 10/15/2024

Implemented [REDACTED] - 12/04/2024)

82c - Locking Poisonous Materials

3. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

There was 6 ounce bottle of nail polish remover, labeled "Extremely flammable. Contact physician. Harmful if ingested. In case of accidental ingestion, give fluids liberally and consult with local poison control center." unsecured, unattended and accessible to residents, under the sink in the shared bathroom in bedroom #9.

82c - Locking Poisonous Materials (continued)

Resident #2's initial assessment, dated [REDACTED]/24, indicates the resident is unable to safely handle hazardous materials.

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

1. Nail polish remover immediately removed from unsecure area and placed in secured area away from direct resident access during siter inspection on 7/25/24.
2. Check of all apartments completed for any additional combustible or flammable material by Medication Associate on duty on 7/25/24.
3. Regulation reviewed with team members on shift on 7/25/2024 by Resident Wellness Director and Executive Operations Officer.

Preventative Action:

1. Community staff will be educated on Regulation 82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.
2. Training will be completed by Executive Operations Officer on 9/24/2024.
3. Designated Team Member will be assigned "Poisonous Material Audit" for daylight, evening, and midnight shifts daily following training.

Corrective Action:

1. Daily audit for poisonous, hazardous material will be completed by designated team member once per shift. This process to begin no later than 9/30/2024.
2. Audit will be documented on Daily Assignment Sheet by team member who has completed the audit. This process to begin no later than 9/30/2024.
3. Life Stories Director will verify that audit has been completed by checking Daily Assignment Sheet. LSD will initial Daily Assignment Sheet to verify review. This process to begin no later than 9/30/2024.

Licensee's Proposed Overall Completion Date: 09/27/2024

Implemented [REDACTED] - 12/04/2024)

125a - Combustible Storage

4. Requirements

125a - Combustible Storage (continued)

2600.

125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

There was 6 ounce bottle of nail polish remover, labeled "Extremely flammable. Contact physician. Harmful if ingested. In case of accidental ingestion, give fluids liberally and consult with local poison control center." unsecured, unattended and accessible to residents, under the sink in the shared bathroom in bedroom #9

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

1. Nail polish remover immediately removed from unsecure area during site inspection on 7/25/24.
2. Check of all apartments completed for any additional combustible or flammable material by Medication Associate on duty on 7/25/24.

Preventative Action:

1. Community staff will be educated on Regulation 125.a. - Combustible and flammable materials may not be located near heat sources or hot water heaters.
2. Training will be completed by Executive Operations Officer on 9/24/2024.

Corrective Action:

1. Designated Team Member will complete audits once throughout their shift for any combustible or flammable materials by 9/30/2024.
2. Audit will be documented on Daily Assignment Sheet by team member completing audit by 9/30/2024.
3. Life Stories Director will verify that audit has been completed by checking Daily Assignment Sheet by 9/30/2024.

Licensee's Proposed Overall Completion Date: 09/26/2024

Implemented [REDACTED] - 12/04/2024)

132c - Fire Drill Records

5. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record did not document the evacuation time in minutes and seconds on the following dates: 1/26/24, 3/29/24, 5/20/24 and 6/29/24.

Plan of Correction

Accept [REDACTED] 09/20/2024)

Immediate Action:

1. Executive Operations Officer reviewed Regulation 132.c. A written fire drill record must include the **date, time,**

132c - Fire Drill Records (continued)

the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative. with Safety and Maintenance Engineer and Resident Wellness Director on 7/26/2024.

2. Fire Drill conducted on 7/30/2024 monitored by EOO and documentation reviewed post-drill with SME and RWD. Drill time documented per regulatory guidelines.

Preventative Action:

1. Community staff will be education on Regulation 132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative on 9/24/2024.

2. Training will be conducted by Executive Operations Officer.

Corrective Action:

1. SME, RWD, EOO will review fire details of fire drill, including time, documentation, participation, challenges, following each drill no later than 9/30/24. Verification of review will be identified by initials of SME, RWD, and EOO on "Fire Drill Report."

2. Details of drill, including time, documentation, participation, and challenges will be reviewed during Monthly Safety Committee Meeting by 9/30/2024.

3. Executive Operations Officer will maintain Fire Drill Log and verify completeness monthly. Audit will be verified by EOO initials on Fire Drill Log. This process to begin no later than 9/30/24.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [redacted] - 12/04/2024)

132d - Evacuation

6. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

132d - Evacuation (continued)

Description of Violation

According to multiple staff interviews, the home conducted a fire drill on or about 6/22/24 which exceeded the safe evacuation time of 15 minutes. The home failed to record this fire drill on the fire drill record. The home then conducted a second fire drill on 6/29/24 which was recorded on the fire drill record.

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

1. Community staff will be educated on regulation 132.d. - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.
2. Education will be completed by Executive Operations Officer on 9/24/24 with use of RCG.
3. Documentation from reported failed June drill will be reviewed during training to identify challenges and interventions that have been put in place to prevent further challenges.

Preventative Action:

1. Executive Operations Officer will coordinate and observe drills with Safety and Maintenance Engineer to assure successful evacuation of residents and community staff within time designated by Fire Safety Expert.
2. Drills not meeting regulatory guidelines will be immediately reviewed by SME and EOO to identify cause of failure.
3. Any failed drills will be reported per regulatory guidelines and repeated within same calendar month on designated shift.

Corrective Action:

1. Safety and Maintenance Engineer and Executive Operations Officer will meet following each fire drill to review details including date/time, location, evacuation route, successfulness, and challenges. This process will begin no later than 9/30/2024.
2. Any challenges will be documented on Fire Drill Log and reviewed with the team during the next monthly department meetings and quarterly all staff meeting. This process will begin no later than 9/30/2024.
3. Fire Drill(s) details will be reviewed post-drill with the responding team, during monthly Safety and Quality Assurance Meetings, and monthly Resident Council Meetings by SME or EOO. This process will begin no later than 9/30/2024.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 12/04/2024)

132g - Fire Drills Days/Times

7. Requirements

2600.

132g - Fire Drills Days/Times (continued)

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills at the end of each month. Fire drills were conducted on 1/26/24, 2/26/24, 4/26/24, 3/29/24 and 6/29/24.

Plan of Correction

Accept [redacted] - 09/20/2024)

Immediate Action:

- 1. Executive Operations Officer provided Safety and Maintenance Engineer with education on Regulation 132.g. - Fire drills shall be had on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low on 7/26/2024.
- 2. EOO and SME reviewed plan to change have August 2024 drill completed before the 20th of August, as July drill is scheduled for 7/30/24.

Preventative Action:

- 1. Community staff will be educated on regulation 132.g. - Fire drills shall be had on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. Training will be completed on 9/24/2024.
- 2. Safety and Maintenance Engineer and Executive Operations Officer will coordinate shift, date, and time of fire drill for designated month be completed on a different shift than the previous month and not within 5 days of the date of previous months drill.
- 3. SME will verify that date/time for previous drill by checking the Fire Drill Log to verify dates beginning August 2024.

Corrective Action:

- 1. SME, RWD, EOO will review fire details of fire drill, including date, time, documentation, participation, challenges, following each drill beginning September 2024. Verification of review will be identified by initials of SME, RWD, and EOO on "Fire Drill Report."
- 2. Details of drill, including time, documentation, participation, and challenges will be reviewed during Monthly Safety Committee Meeting.
- 3. Executive Operations Officer will maintain Fire Drill Log and verify completeness monthly. Audit will be verified by EOO initials on Fire Drill Log beginning September 2024.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [redacted] - 12/04/2024)

184a - Resident's Meds Labeled

8. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

184a - Resident's Meds Labeled (continued)

Description of Violation

Resident #1 is prescribed Buspirone 7.5mg – take one tab by mouth three times daily. However, the medication label indicates Buspirone 5mg – take one tab by mouth twice a day.

Resident #1 is prescribed Furosemide 20mg – take two tabs by mouth once daily. However, the medication label indicates Furosemide 20mg – take one tab by mouth twice a day

Resident #1 is prescribed Metoprolol 25mg – take one tab by mouth twice daily. However, the medication label indicates Metoprolol 50mg – take one tab by mouth twice daily

Resident #1 is prescribed Senna 8.6mg – take one tab by mouth every 24 hours as needed. However, the medication label indicates RA LAX Senna – take one tab by mouth at bedtime

Repeat Violation: 2/28/24

Plan of Correction

Accept [REDACTED] - 09/20/2024)

Immediate Action:

1. Medication Audit completed on 8/8/24 by [REDACTED] designee.
2. Medication labels were compared to physician order for medications to verify that label and order match.
3. Medication labels that did not match the physician order were identified and corrected with use of "Direction Change - Refer to MAR" sticker.
4. [REDACTED] reviewed documentation from medication audit and confirmed all appropriate changes we made on 8/10/2024.

Preventative Action:

1. Medication Associates and LPN Supervisors will be educated on Regulation 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes resident name, medication name, medication dosage, and frequency.
2. Education will be provided by Executive Operations Officer on 9/24/24.

Corrective Action:

1. Designated Medication Associate will complete medication cart audit once per month. This process will begin no later than 10/31/2024.
2. Findings of audit will be documented on audit form and reported to Resident Wellness Director for follow up. This process will begin no later than 10/31/2024.
3. Resident Wellness Director will complete audit on 3 randomly selected residents per week to verify compliance. Audit will be documented with initials of resident medications who were audited. This process will begin no later than 10/31/2024.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 12/04/2024)

187a - Medication Record

9. Requirements

187a - Medication Record (continued)

2600.

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

Description of Violation

Resident #2 is prescribed he following medications:

**acetaminophen 325mg – take 2 tabs by mouth every 4 hours as needed,*

**bisacodyl 5mg – take one tablet by mouth as needed*

**stimulant LX tab 8.6-50mg – take one tab by mouth as needed*

However, these medications were not documented on the resident's July 2024 Medication Administration Record (MAR).

Plan of Correction

Accept [redacted] - 09/20/2024)

Immediate Action:

1. *Audit of Medication Administration Records to be completed by designated team member by 8/30/24.*
2. *Any medications that have not been signed for will be documented on audit sheet and reconciled by Resident Wellness Director.*
3. *Document findings will be reviewed during training held by EOO on 9/24/2024.*

Corrective Action:

1. *Medication Associates and LPN Supervisors will be provided with education related to Regulation - 187.a. A medication record shall be kept including the following for each resident for whom medications are administered:*
2. *Executive Operations Officer will be completed on 9/24/2024.*

Preventative Action:

1. *Resident Wellness Director will conduct weekly audit to verify that all medications have been signed for or documented appropriately according to resident status. This process will begin no later than 10/31/2024.*
2. *Audit findings will be reviewed during monthly department meetings by Resident Wellness Director by 11/30/2024 .*

Licensee's Proposed Overall Completion Date: 11/30/2024

Implemented [redacted] - 12/04/2024)

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

Facility Information

Name: *NEWHAVEN COURT AT CLEARVIEW* License #: *42346* License Expiration: *10/23/2024*
Address: *100 NEWHAVEN LANE, BUTLER, PA 16001*
County: *BUTLER* Region: *WESTERN*

Administrator

Name: [REDACTED]

Legal Entity

Name: *TITHONUS BUTLER LP*
Address: [REDACTED]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *134* Waking Staff: *101*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident, Monitoring* Exit Conference Date: *10/16/2024*

Inspection Dates and Department Representative

10/16/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *115* Residents Served: *96*

Secured Dementia Care Unit

In Home: *Yes* Area: *Life Stories* Capacity: *18* Residents Served: *17*

Hospice

Current Residents: *13*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *96*
Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *38* Have Physical Disability: *0*

Inspections / Reviews

10/16/2024 - Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *11/02/2024*

Inspections / Reviews (*continued*)

11/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 12/16/2024

12/09/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/09/2024

Reviewer: [REDACTED]

Follow-Up Type: Exception

185a - Implement Storage Procedures

1. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1 is prescribed ondansetron 4mg – take one tablet every 4 hours as needed. However, this medication was not available in the home.

Resident #1 is prescribed Nystatin Cream 100000 – apply topically to affected areas as needed. However, this medication was not available in the home.

Plan of Correction

Accept [REDACTED] - 11/12/2024)

Immediate Action:

1. Nystatin Cream 10000 and Ondansetron 4mg ordered from Rainer's Pharmacy on 10/16/2024 by LPN Supervisor.
2. Community staff educated on 10/16/2024 on regulation 185.a. during shift change by Resident Wellness Director. [REDACTED] Hospice Team informed that if medications are not delivered by their pharmacy at the time medication is ordered, medication will be ordered from community pharmacy to assure it is accessible. This process to began 10/16/2024.
3. Medication Audit completed on 10/18/2024 by Resident Wellness Director Designee to verify that all medications ordered for residents residing in the community are available on site.

Preventative Action:

1. Resident Wellness Director will provide education utilizing RCG on regulation 185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons, during November department meeting.
2. [REDACTED] Hospice informed that medications were not delivered by [REDACTED] Pharmacy by Resident Wellness Director on 10/16/2024.

Corrective Action:

1. Resident Wellness Director will develop process to assign one Medication Associate to each medication cart within the community by 11/30/2024.
2. Designated Medication Associate that is assigned to medication cart will be responsible for completely 2 audits per month to ensure all access to all ordered medications. This process will begin no later than 12/16/2024.
3. Medication Associate will identify all findings of audit on Medication Audit, identify the immediate action taken, and return to Resident Wellness Director for review.
4. Resident Wellness Director will review each Medication Audit Sheet and verify that all findings were addressed and rectified. RWD will initial Medication Audit and keep of proof of completion and review.

Licensee's Proposed Overall Completion Date: 12/15/2024

Implemented [REDACTED] - 12/09/2024)