Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

June 27, 2025

TITHONUS BEDFORD LP
C/O INTEGRACARE CORPORATION

RE: COLONIAL COURTYARD AT BEDFORD
220 DONAHUE MANOR ROAD
BEDFORD, PA, 15522
LICENSE/COC#: 32948

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/29/2025 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 BEDFORD* **License #**: *32948* **License Expiration**: *06/05/2025*

Address: *220 DONAHUE MANOR ROAD, BEDFORD, PA 15522*

County: *BEDFORD* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *TITHONUS BEDFORD LP*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/12/2000* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *05/29/2025*

Inspection Dates and Department Representative

05/29/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *83* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *16* **Residents Served**: *14*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *32* **Have Physical Disability**: *1*

Inspections / Reviews

05/29/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/28/2025*

06/26/2025 - POC Submission

Submitted By: **Date Submitted**: *06/26/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/03/2025*

Inspections / Reviews *(continued)*

06/27/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *06/26/2025*

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

17 Record Confidentiality

1. Requirements

2600.

17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On [redacted] staff person A was in the wellness center office of the home while posting a video to snapchat, a social media platform, which was available for view by the general public. The staff person was standing in front of the shelves containing all of the home's resident records. Confidential resident information for all residents was visible in the video. On [redacted], Staff person A was terminated as a result of this incident.

Plan of Correction ***Accept [redacted] 06/26/2025)***

1. Violation Review: 2600.17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2. Violation Interpretative Statement- On [redacted], staff person A was in the wellness center office of the home while posting a video to snapchat, a social media platform, which was available for view by the general public. The staff person was standing in front of the shelves containing all of the home's resident records. Confidential resident information for all residents was visible in the video. On [redacted] Staff person A was terminated as a result of this incident.

3. Review the Benefit of the Regulations, per RCG.- Protects resident privacy and ensures that homes comply with other applicable laws

4. Description of Repair of the Immediate Problem- Team member was suspended for investigation and was termed due to infraction of policy of Record Confidentiality.

5. Determine/ document the Root Cause of the Violation- Lack of process to ensure compliance with 2600.17.

6. Detail Action Steps/ System Developed to prevent future occurrence- Staff meeting and trainings have been ongoing to make staff aware of policy of cellphones and recordings or photos inside the community. Trainings were discussed about handbook policy on Cell phone usage on 1/22/2025, posted updated given on 2/13/2025 and 4/23/25. As well as team meeting on 6/24/25. Managers of each department are monitoring cell phone usage around the community and reminding staff to keep their cell phones in their lockers or breakroom area.

7. Designated position responsible and specify target date for Correction- Moving forward and ongoing Executive Operations Officer and Resident Wellness Director will review Cell phone usage policy and HIPPA policies with staff members at Monthly staff meeting and signs of cellphone usage and no usage areas have been posted around the

17 Record Confidentiality (continued)

community as of 4/23/2025. We continue to educate the team on policies for cell phones and hold the team members to the policy of one day suspension on first occurrence and then the next time termination.

Licensee's Proposed Overall Completion Date: *06/25/2025*

Implemented (- 06/27/2025)

23b - Instrumental Activities of Daily Living Assistance

2. Requirements

2600.
23.b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

Description of Violation

The assessment and support plans for resident , dated and indicate the resident requires assistance with eating/feeding during mealtimes. On and , the resident did not receive this assistance as required per support plan. Meal trays were dropped off at the resident's room, but staff did not stay to assist the resident with eating. On these occasions, the resident's family members entered the resident's room later in the evening to find the untouched meal trays in the room. Staff person A was disciplined for the resident's missed meal on

Plan of Correction ***Accept - 06/26/2025)***

1. Violation Review 2600. 23b. A home shall provide each resident with assistance with IADLs as indicated in the resident's assessment and support plan.

2. Violation Interpretative Statement The assessment and support plans for resident dated and indicate the resident requires assistance with eating/feeding during mealtimes. On and the resident did not receive this assistance as required per support plan. Meal trays were dropped off at the resident's room, but staff did not stay to assist the resident with eating. On these occasions, the resident's family members entered the resident's room later in the evening to find the untouched meal trays in the room. Staff person A was disciplined for the resident's missed meal on

*3. Review the benefit of the Regulations, per RCG Ensures that residents' needs are met once those needs have been assessed and a plan to meet
the needs has been developed.*

4. Description of Repair of the Immediate Problem: Staff were educated about the importance of providing care and assisting to feed residents that need help. even disciplined when needed,

5. Determine/ document the Root Cause of the Violation: Lack of Process to ensure compliance with 2600.23.b.

6. Detail Action Steps/ System Developed to prevent future occurrence. Resident Wellness Director and Executive Operations Officer educated team on 1/22/2025, 2/19/2025,3/13/2025,3/21/2025, and 6/11/25 and 6/24/25 for reminders on meal trays and proper standards. On 2/22/25 Quick Mar was started for all residents unable to fed themselves do to decline to follow support plan. Quick Mar will put in meal checks for Breakfast, Lunch and Dinner to monitor meal and intake for residents needing that care. As well as refusal papers are in place if 3 refusals of

23b - Instrumental Activities of Daily Living Assistance (continued)

meals are done be a resident.

7. Designated position responsible and specify target date for correction: As of 12/9/25 on ongoing educations have been giving to team members about the importance of feeding residents that need assistance. Training and reminders have been put in place and ongoing by the Resident Wellness Director and will insure with the Quick Mar system that all documentation of feeding assist will be implemented and monitor monthly. EOO will follow-up and monitor these at the end of each month.

Licensee's Proposed Overall Completion Date: *06/25/2025*

Implemented - 06/27/2025)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On at 9:55 AM, a small white pill marked with marked "U" on one side and "2" on the other, which was identified as , was observed on the floor of the main dining room.

Plan of Correction ***Accept - 06/26/2025)***

1. Violation Review 2600.183.b.-Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2. Violation Interpretative Statement- On 5/29/25, at 9:55 AM, a small white pill marked with marked "U" on one side and "2" on the other, which was identified as Mirapex 0.125 mg, was observed on the floor of the main dining room.

3. Review the benefit of the Regulations, per RCG- Medications and syringes will be safe from contamination, spillage or theft and residents who
are unable to self-administer medications will be safe from harming themselves with the medications.

4. Description of Repair of the Immediate Problem- Pill was removed from floor under table number 6 and taken to wellness center where investigation of resource was started. Findings were that only one resident in the community was prescribed this medication sits at table number 7 which is across the room from table 6. Not knowing if it was actually and if it could have been a guest sitting at that table prior to the floor being swept. Results were unfounded and no reportable was completed due to the unknown, but training was being put into place.

5. Determine/document the Root Cause of the Violation- Lack of Process to ensure compliance with 2600.183.b

6. Detail Action Steps/ System Developed to prevent future occurrence- On 6/24/25 Staff meeting was conducted with all team members discussed daily walk throughs of all common areas, resident rooms and medication storage areas to ensure all medications are secured. Remove any medications and proper dispose of that are unsecured. Document findings and any actions taken. Training went over the importance of medication security and the implications of the violation. Team members were all reeducated on the proper steps to a med pass focusing on close observations of resident taking medications. Staff will be monitored by leadership with weekly rounds check sheet

183b - Meds and Syringes Locked (continued)

to follow up with handling policies to identify and address any gaps or weaknesses. These rounds are to start on 6/25/25 and continue for three months weekly then go to monthly after September 30, 2025. EOO will assign managers weekly assignments in morning standup.

7. Designated position responsible and specify target date for correction- Resident Wellness Director will monitor along with Executive Operations Officer twice weekly on different shifts for three months till September 30, 2025 and then monthly following that date. Executive Operations Officer will ensure that inspection of proper handling and will educate moving forward and ongoing as on 6/25/25.

Licensee's Proposed Overall Completion Date: *06/25/2025*

Implemented ██ - 06/27/2025)