Department of Human Services
Bureau of Human Service Licensing

June 10, 2021

[redacted] PRESIDENT & COO
TITHONUS MT. LEBANON LP
6600 BROOKTREE COURT SUITE 1000
C/O INTEGRACARE CORP
WEXFORD, PA 15090

RE: THE PINES OF MT. LEBANON
1537 WASHINGTON ROAD
PITTSBURGH, PA, 15228
LICENSE/COC#: 43361

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/25/2021, 03/26/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Jon Kimberland

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *THE PINES OF MT LEBANON* **Licen e #**: *43361* **Licen e Expiration Date**: *06/03/2021*
Addre : *1537 WASHINGTON ROAD, PITTSBURGH, PA 15228*
County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: *4123414400* **Email**: [redacted]

Legal Entity

Name: *TITHONUS MT. LEBANON LP*
Address: *6600 BROOKTREE COURT SUITE 1000, C/O INTEGRACARE CORP, WEXFORD, PA, 15090*
Phone: *4123414400* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/06/1989* **Issued By**: *L & I*

Staffing Hours

Re ident Support Staff: *0* **Total Daily Staff**: *59* **Waking Staff**: *44*

Inspection

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Incident* **Exit Conference Date**: *03/25/2021*

Inspection Dates and Department Representative

03/25/2021 - On-Site: [redacted]
03/26/2021 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *112* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *18* **Residents Served**: *10*

Hospice

Current Re ident : *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *40*
Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *22* **Have Physical Disability**: *1*

Inspections / Reviews

03/25/2021 - Partial

Lead In pector: [redacted] **Follow Up Type:** *POC Submission* **Follow-Up Date:** *04/30/2021*

4/30/2021 POC Submi ion

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/03/2021*

6/10/2021 - Document Submission

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

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Repeat Violation

On 3/16/21, at approximately 5:00 p.m., direct care staff person B, walked by resident #1's room and witnessed direct care staff person D feeding the resident and leaning forward towards resident #1's face and mocking the resident by making noises at the resident.

On 3/16/21, at approximately 7:00 p.m., direct care staff person A and D were providing incontinence care to resident #1 in his/her bed. During bladder and bowel incontinence care resident #1, always make loud, Ahhhh! Sounds. Direct care staff person C reported direct care staff person D had stated about four times, "Oh shut up, I hate that noise, shut up", in a mocking manner and was laughing while still providing incontinence care to resident #1. Direct care staff person D had also stated, "Resident #1 is shitting too much, if he/she shits again, I'm going to leave it for midnight, and I don't give a fuck what [redacted] has to say."

The home did not report the incident to the Area Agency on Aging/Protective services until 3/19/21.

(11/18/2020 Repeat)

15a - Resident Abuse Report *(continued)*

Plan of Correction **Accept**

Community Name: The Pines of Mount Lebanon
License Number: 433610
Date of Visit: 03/25/2021
Date of Submission: 04/30/2021

1. Violation Review: 2600.15a.
The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act and comply with the requirements regarding restrictions on staff persons.

2. Violation Interpretative Statement:

The home did not report the incident which occurred on 3/16/21 until 3/19/21.

3. Review the benefit of the Regulation, per RCG:
Ensures that abuse or suspected abuse is appropriately reported and investigated.

4. Description of the Repair of the Immediate Problem:
Regional Wellness and Operations Specialist met with the leadership team on 3/19/2021 to review regulation 2600.15a and the reporting expectations and procedures for potential abuse situations. The review of the requirement is documented.
5. Determine / document the Root Cause of the Violation:
Education about 2600.15a was needed by the team to understand and comply with 2600.15a.

6. Detail Action Steps / System Developed to prevent future occurrence:
Training occurred with leadership team on 3/19/2021.

a. Teaching or Training?
As indicated above, training occurred on 3/19/2021. Training will be reinforced weekly during the leadership morning stand-up meetings.

7. Designated position responsible and specify target date for correction.
Training of the leadership team was completed on 3/19/21

Completion Date: *03/19/2021*

Document Submission **Implemented**

The training was conducted and evidence has been submitted

15b - Supervisor Plan

1. **Requirements**
2600.

15b - Supervisor Plan *(continued)*

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 3/16/21, at approximately 5:00 p.m., direct care staff person B, walked by resident #1's room and witnessed direct care staff person D feeding the resident and leaning forward towards resident #1's face and mocking the resident by making noises at the resident.

On 3/16/21, at approximately 7:00 p.m., direct care staff person A and D were providing incontinence care to resident #1 in his/her bed. During bladder and bowel incontinence care resident #1, always make loud, Ahhhh! Sounds. Direct care staff person C reported direct care staff person D had stated about four times, "Oh shut up, I hate that noise, shut up", in a mocking manner and was laughing while still providing incontinence care to resident #1. Direct care staff person D had also stated, "Resident #1 is shitting too much, if he/she shits again, I'm going to leave it for midnight, and I don't give a fuck what [redacted] has to say."

Direct care staff person D was not placed on a plan of supervision and provided unsupervised care to residents in the home was not removed from the assigned shift until approximately 8:30 p.m. on 3/16/21. Direct care staff person D then worked in the home and provided direct care services on 3/17/21 from 2:00 p.m. to 10:30 p.m.

15b - Supervisor Plan *(continued)*

Plan of Correction **Accept**

Community Name: The Pines of Mount Lebanon
License Number: 433610
Date of Visit: 03/25/2021
Date of Submission: 04/30/2021

1. Violation Review:
2600.15b. If there is an allegation of abuse of a resident involving a home staff person the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

2. Violation Interpretative Statement:
To ensure abuse and suspected abuse is appropriately investigated.

3. Review the benefit of the Regulation, per RCG:
To ensure abuse and suspected abuse is appropriately investigated.

4. Description of the Repair of the Immediate Problem:
All leadership staff were educated on 3/19/2021 that is there are any accusations or suspected abuse the staff person will immediately be removed from their shift and future scheduled shifts until an investigation has been completed.
5. Determine / document the Root Cause of the Violation:
The staff member was asked to leave [redacted] shift immediately upon reporting of the allegation to the EOO. [redacted] was allowed to return to work the following day after meeting with the EOO and Administrative Services Director.
6. Detail Action Steps / System Developed to prevent future occurrence:
All leadership staff were educated on 3/19/2021 that is there are any accusations or suspected abuse the staff person will immediately be removed from their shift and future scheduled shifts until an investigation has been completed.

7. Designated position responsible and specify target date for correction.
Training was completed by Regional Wellness and Operations Specialist on 3/19/21.

Completion Date: *03/19/2021*

Document Submission **Implemented**

Training was provided and managers understand the need to report and make a plan for supervision in an abuse situation.

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).

16c - Written Incident Report *(continued)*

Description of Violation

On 3/16/21, at approximately 5:00 p.m., direct care staff person B, walked by resident #1's room and witnessed direct care staff person D feeding the resident and leaning forward towards resident #1's face and mocking the resident by making noises at the resident.

On 3/16/21, at approximately 7:00 p.m., direct care staff person A and D were providing incontinence care to resident #1 in his/her bed. During bladder and bowel incontinence care resident #1, always make loud, Ahhhh! Sounds. Direct care staff person C reported direct care staff person D had stated about four times, "Oh shut up, I hate that noise, shut up", in a mocking manner and was laughing while still providing incontinence care to resident #1. Direct care staff person D had also stated, "Resident #1 is shitting too much, if he/she shits again, I'm going to leave it for midnight, and I don't give a fuck what [redacted] has to say."

However, the allegation of abuse was not reported to Department until 3/19/21, at approximately 12:30 p.m.

16c - Written Incident Report *(continued)*

Plan of Correction **Accept**

Community Name: The Pines of Mount Lebanon
License Number: 433610
Date of Visit: 03/25/2021
Date of Submission: 04/30/2021

1. Violation Review:
2600.16c. 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.

2. Violation Interpretative Statement:
The home did not report the 3/16/21 incident to the department until 3/19/21.

3. Review the benefit of the Regulation, per RCG:
Reporting incidents allows the Department to respond promptly to serious situations, and offers homes the opportunity to provide information that may reduce the need for the Department to pursue additional information.

4. Description of the Repair of the Immediate Problem:
All leadership staff were educated on 3/19/21 by the Regional Wellness and Operations Specialist regarding reporting requirements.
5. Determine / document the Root Cause of the Violation:
The EOO and Administrative Services Director met with Staff Member D the day after the alleged incident to discuss/investigate. The employee was adamant that the reported behavior did not occur.

6. Detail Action Steps / System Developed to prevent future occurrence:
All leadership staff were trained on 3/19/2021 by the Regional Wellness and Operations Specialist regarding reporting requirements.
a. Teaching or Training? As indicated above. Training completed on 3/19/2021

7. Designated position responsible and specify target date for correction.
Training was completed by the Regional Wellness and Operations Specialist on 3/19/2021.

Completion Date *03/19/2021*

Document Submission **Implemented**

The incident report was submitted, retroactively.

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

42c - Treatment of Residents *(continued)*

Description of Violation

On 3/16/21, at approximately 5:00 p.m., direct care staff person B, walked by resident #1's room and witnessed direct care staff person D feeding the resident and leaning forward towards resident #1's face and mocking the resident by making noises at the resident.

On 3/16/21, at approximately 7:00 p.m., direct care staff person A and D were providing incontinence care to resident #1 in his/her bed. During bladder and bowel incontinence care resident #1, always make loud, Ahhhh! Sounds. Direct care staff person C reported direct care staff person D had stated about four times, "Oh shut up, I hate that noise, shut up", in a mocking manner and was laughing while still providing incontinence care to resident #1. Direct care staff person D had also stated, "Resident #1 is shitting too much, if he/she shits again, I'm going to leave it for midnight, and I don't give a fuck what [redacted] has to say."

42c - Treatment of Residents *(continued)*

Plan of Correction **Accept**

Community Name: The Pines of Mount Lebanon
License Number: 433610
Date of Visit: 03/25/2021
Date of Submission: 04/30/2021

1. Violation Review: 2600.42c.
A resident shall be treated with dignity and respect.

2. Violation Interpretative Statement:
Direct care staff person B witnessed direct care staff person D mocking the resident.
Direct care staff person A also witnessed direct care staff person D telling the resident to "shut up" about 4 times during care.

3. Review the benefit of the Regulation, per RCG:
Ensures that residents are treated in a respectful and dignified manner.

4. Description of the Repair of the Immediate Problem:
Direct care staff person D was sent home from [redacted] shift immediately upon the EOO being notified of the behavior in question.

5. Determine / document the Root Cause of the Violation:
Despite documented training, Staff person D made the personal choice to not interact with the resident in a respectful manner. The incident was identified and reported by team members having the same training.
6. Detail Action Steps / System Developed to prevent future occurrence:
Direct Care Staff Person D resigned [redacted] position during the course of the investigation.

7. Designated position responsible and specify target date for correction.
Direct care staff person D resigned her position during the course of the investigation.
No additional needs identified.

Completion Date: *03/19/2021*

Document Submission **Implemented**

The staff person resigned during the investigation.