



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

**Mailing Date: October 30, 2019**

Mr. Timothy Buchanan  
Managing Member  
Lititz PCH LLC  
80 West Millport Road  
Lititz, Pennsylvania 17543

RE: Legend Personal Care and Memory Care of Lititz  
Certificate #: 332980

Dear Mr. Buchanan:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on October 7, 2019 and October 8, 2019 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is:  
Acceptable - All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

If you need assistance, please contact me at 717-418-9656 or email at [bswanger@pa.gov](mailto:bswanger@pa.gov).

Sincerely,

A handwritten signature in black ink that reads "Brett Swanger".

Brett Swanger  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

# Violation Report

## Facility Information

**Name :** LEGEND PERSONAL CARE AND MEMORY CARE OF LITITZ

**License Number :** 33298

**Address :** 80 WEST MILLPORT ROAD,, LITITZ, PA 17543

**County:** LANCASTER

**Region:** CENTRAL

## Administrator

**Name :** Terri Sanelli

**Phone :** 7172834255

**Email :**

## Legal Entity

**Name :** LITITZ PCH LLC

**Address:** 80 WEST MILLPORT ROAD, LITITZ, PA, 17543

## Certificate(s) of Occupancy

**Type :** I-1

**Date :** 11/18/2016

**Issued By :** Warwick Township

## Staffing Hours

**Resident Support Staff :** 0

**Total Daily Staff:** 114

**Waking Staff :** 86

## Inspection

**Type :** Full

**BHA Docket # :**

**Notice :** Unannounced

**Reason :** Renewal,Incident

## Inspection Dates and Department Representative

10/07/2019 - On-Site: Jason McCloskey, Kellie Cargile

10/08/2019 - On-Site: Jason McCloskey, Kellie Cargile

## Resident Demographic Data as of Inspection Dates

### General Information

**License Capacity:** 100

**Residents Served :** 76

### Secured Dementia Care Unit

**In Home :** Yes

**Area:** Reflections

**Capacity:** 40

**Residents Served :** 31

### Hospice

**Current Residents :** 3

### Number of Residents Who:

**Receive Supplemental Security Income:** 0

**Are 60 Years of Age or Older :** 76

**Diagnosed with Mental Illness :** 0

**Diagnosed with Intellectual Disability:** 0

**Have Mobility Need :** 38

**Have Physical Disability :** 0

65g - Annual TrainingContent

**Regulations**

**2600.**  
**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 members A and B did not receive training in emergency preparedness procedures and in-person fire safety training during the calendar training year 2018.

Ancillary staff member C did not receive training in resident rights during calendar training year 2018.

Repeat Violation: 10/17/2018

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Complete training audit completed. Staff member C has completed resident rights training on 10/14/2019 all staff will receive in person fire training on 10/30/19 and 11/4/19 and emergency preparedness procedures on 10/30/19 and 11/4/19. Residence Director or designee will monitor for ongoing compliance through the following. Training records will be reviewed quarterly meeting by Customer Service Associate or Residence Director. All documentation will be provided to DHS by 11-15-2019.

**Legal Entity Representative**

\_\_\_\_\_  
 Signature Printed Name and Title Date

**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!**

The above plan of correction is approved as of 10/30/2019 Plan of correction implementation status as of \_\_\_\_\_  
 (Date) (Date)

The above plan of correction was approved by BAS  
 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

65i - Training Record

**Regulations**

**2600.**

**65.i.** A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

**Description of Violation**

Direct Care Staff members D and E received training in the topics required under regulation 2600.65(b) during training year 2018. However the home could not provide the records for the completion of these trainings.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Complete training audit completed. All staff scheduled to complete training by 11-15-19. All documentation will be provided to DHS by 11-15-19. Moving forward staff training record provided by DHS will be utilized for all staff training excluding Relias training. Relias certificates are available along with a full training report that meets the 2600. 65i regulation. Residence Director or designee will continue to monitor for ongoing compliance quarterly.

**Legal Entity Representative**

\_\_\_\_\_  
Signature

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\_\_\_\_\_  
Date

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82c- Locking Poisonous Materials

**Regulations**

**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 a container of Clorox Healthcare Multi Surface Wipes located in an unlocked cabinet in the Reflections secure dementia care unit (SDCU) activity area and accessible to resident who have not been assessed to be able to safely use/avoid poisonous materials. This product is a poisonous material based upon the manufacturer label's directions to contact a poison control center or doctor for treatment.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Staff person in activities area had just left after cleaning tables prior to activity. Staff retrained on safety and use of poisonous materials and requirement to keep poisonous materials locked at all times when not in use. Regulation will be reviewed again with staff in all staff training November 2019, documentation of training will be provided to the DHS by 11-15-2019. In addition, administrator or designee will check SDCU daily x 10 days and documentation will be provided to DHS. Starting November 1, 2019, administrator or designee will perform weekly and random checks throughout SDCU.

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89b - Hot Water Temperature

**Regulations**

**2600.**

**89. b.** Hot water temperature in areas accessible to the resident may not exceed 120°F.

**Description of Violation**

On 10/7/19, at 10:20am the hot water from the sink in the lower-level resident laundry room measured 126 degrees Fahrenheit,

at 10:25am the hot water from the Bistro sink measured 126 degrees Fahrenheit, at 10:30am the hot water from the sink in the Reflections activity room measured 124 degrees Fahrenheit, and at 2:05pm the hot water from the sink in bedroom 141 measured 124 degrees Fahrenheit.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

On day of inspection Leo Kolb, contractor, came to repair hot water heater. Water temperature from multiple sinks to be tested by Maintenance Director, Residence Director or designee weekly to ensure proper temperature maintained. Documentation of water temperatures shall be provided to DHS by 11-30-2019.

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126a - Furnace Inspection

**Regulations**

**2600.**  
**126. a.** A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

**Description of Violation**

The manufacturer’s instructions state the home's furnace units should be inspected by a qualified installer or service agency at least once per year at the beginning of the heating season. The home’s furnaces have not been inspected within the past 365 days.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Annual Furnace inspection completed 10-18-2019, see attached documentation. Maintenance Director will ensure that 2020 inspection will be scheduled prior to 10-18-2020. Residence Director or designee will review compliance quarterly during QM meetings.

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132e - Fire Drill Sleeping Hours

**Regulations**

2600.

132. e. A fire drill shall be held during sleeping hours once every 6 months.

**Description of Violation**

The most recent fire drill held during sleeping hours was on 9/20/19. The previous sleeping hour fire drill was held on 2/25/19.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Sleeping hour fire drills will be scheduled 3 times a year moving forward. This will ensure the requirement is met. Residence Director and Maintenance Director will work in tandem on executing a schedule for the next 12 months and schedule in advance. Fire Drill record will be reviewed at monthly QM meetings to ensure compliance with regulation.

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183b - Meds and Syringes Locked

**Regulations**

**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**

Resident 1 had a 300-count bottle of 325mg aspirin setting on his bathroom vanity. The resident has not been assessed as capable to self-administer medications and this medication was unlocked and accessible to the resident.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Medication listed above was removed from apartment and is stored in medication cart. Resident 1 was re-educated as to regulation 183b. Regulation was reviewed with residents and families at Family Night October 9<sup>th</sup>, 630pm. In addition, home will be mailing out notice reviewing regulation 183b to all residents and responsible parties. All direct care staff to be re-educated to regulation 183d by 11-1-2019. Residence Director or designee will audit apartments monthly to ensure compliance. Documentation of audits in November will be provided to DHS by 11-30-2019.

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183d - Prescription Current

**Regulations**

**2600.**  
**183. d.** Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

**Description of Violation**

Resident 2 had a 300-count bottle of aspirin stored in the home's medication cart. The bottle had an expiration date of 5/2019.

Resident 3's NovoLog FlexPen was marked with an open date of 8/27 was located in the medication cart on 10/8/2019. The manufacturer instructions state that the insulin may be used up to 28 days after first use.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Residence Director, or designee, will audit medication carts and medication storage areas twice monthly to ensure compliance. All med tech staff re-educated to regulation 183d by 11-1-2019. Documentation of November audits will be provided to DHS by 11-30-2019.

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## 183e - Storing Medications

**Regulations**

- 2600.**  
**183. e.** Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

The medication cart for the SDCU contained two loose, large, white, oval tablets.

**Plan of Correction (POC)**

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Upon review of medication cart there were no other loose medications found. Packaging of these medications in blister cards occasionally causes the seal of blister packs to break causing tablets to fall out of blister card. When this issue occurs loose medications are destroyed per pharmacy and community policy. Currently staff do observe drawers of med cart before the change of shift, which I feel to be sufficient. Staff re-educated that they should inspect cart drawers upon each med pass. Residence Director, or designee, will audit medication carts and medication storage areas twice monthly to ensure compliance. All med tech staff re-educated to regulation 183d by 11-1-2019. Documentation of November audits will be provided to DHS by 11-30-2019.

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