Mailing Date: May 6, 2020

Ms. Margie McCarty,
Executive Director
Manor Care Linden Village of Lebanon PA, LLC
333 North Summit Street, 16th Floor
Toledo, Ohio 43604

RE: Linden Village Manor Care Health Services
100 Tuck Court
Lebanon, Pennsylvania 17042
Certificate # 324270

Dear Ms. McCarty:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 19, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Brett Swanger
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Bureau of Human Services Licensing - Central Region
625 Forster Street, Room 631 | P.O. Box 2675 | Harrisburg, PA 17120
P 717.772.4673 | F 717.783.3956 | www.dhs.pa.gov

Violation Report

Facility Information

Name: *LINDEN VILLAGE MANOR CARE HEALTH SERVICES*
License Number: *32427*
Address: *100 TUCK STREET,, LEBANON, PA 17042*
County: *LEBANON*
Region: *CENTRAL*

Administrator

Name: *Margie McCarty*
Phone: *7172747400*
Email:

Legal Entity

Name: *MANOR CARE LINDEN VILLAGE OF LEBANON PA LLC*
Address: *333 NORTH SUMMIT ST, 16TH FLOOR, TOLEDO, OH, 43604*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *10/01/1998*
Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *87*
Waking Staff: *65*

Inspection

Type: *Full*
BHA Docket #:
Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

02/19/2020 - On-Site: Laura Heemer, Doug Hoover

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64*
Residents Served: *54*

Secured Dementia Care Unit

In Home: *Yes*
Area: *Mount Hope and Tabor*
Capacity: *32*
Residents Served: *32*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *53*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *33*
Have Physical Disability: *0*

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act requires that a carbon monoxide alarm be installed in close proximity, but no less than 15 feet, to any fossil fuel burning device or appliance. There are no carbon monoxide detectors located in the attic for the furnaces in the Quentin, Stoy, Tabor and Mt. Hope cottages of the home.

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.)

Please see Attached

Page 2A

Legal Entity Representative

Signature: Margie McCarty

Printed Name and Title: Margie McCarty Executive Director

Date: 4-2-2020

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

The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented

☐ Not Implemented

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

18

- The Executive Director (ED) and Building Services Coordinator (BSC) reviewed the User's manual regarding the placement of the carbon monoxide alarms. The guidelines state:
  WHERE CO ALARMS SHOULD NOT BE INSTALLED - DO NOT LOCATE THIS CO ALARM:
  In areas where temperature is colder than 40° F (4.4° C) or hotter than 100° F (37.8° C). These areas **include unconditioned crawl spaces, unfinished attics,** uninsulated or poorly insulated ceilings, porches, and garages.
  Attachment: User's Manual.
  Therefore, this would exclude placement in the attic area.

- In addition, the ED and BSC reviewed the National Fire Protection Association 720 Guidelines:
  9.4.1.1* Carbon Monoxide alarms or detectors shall be installed as follows:
  (2) On every occupiable level of a dwelling unit including basements**, excluding attics and crawl spaces.**
  Therefore, this would exclude placement in the attic area.

- The carbon monoxide alarms are located outside the doors leading to the attic in Quentin, Stoy, Tabor, and Mt. Hope Cottages.

- Due to the community's compliance with the Manufacturer's instructions for placement of the carbon monoxide alarms, we respectfully request that Violation 2600.18 be removed.

Margie McCarty Executive Director
Margie McCarty 4/2/2020

85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 2/19/2020 at 10:25 am and 3:40 pm, there was a strong urine odor in the bedroom of Resident #4.

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.)

Please see attached

Page 3A

Legal Entity Representative

Margie McCarty — Signature
Margie McCarty Executive Director — Printed Name and Title
4/2/2020 — Date

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

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Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented
☐ Not Implemented

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85.a.

- Resident #4's bedroom was deep cleaned on 2/20/20 by housekeeping.

- New flooring was ordered on 2/26/20 for the bedroom of Resident #4 due to incontinence and several, unsuccessful attempts to clean the carpet with carpet cleaner.
  Attachment: Quote for new flooring

- Resident #4's RASP was revised by the Executive Director on 2/20/20 to include approaches to address urinary incontinency.
  Attachment: RASP addendum

- Resident #4's bedroom will be deep cleaned twice per week, combined with a room audit conducted by the Building Services Coordinator for the next three months, beginning 3/1/20. The Building Services Coordinator will complete random audits of resident rooms to ensure compliance for sanitary conditions for the next three months, beginning 3/1/20.
  Audit tools will be available for survey review.
  Attachment: Resident Room Deeping Cleaning Checklist

- The Building Services Coordinators and housekeepers were in-serviced regarding regulation 85.a. by the Executive Director on 3/12/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
MARgie McCArty
4/2/2020

100a - Exterior - Free of Hazards

Regulations

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

There is an approximately four inch drop from the sidewalk to the ground at the courtyard sidewalk by the rear porch of the Mount Hope cottage. This drop in height poses a fall hazard for someone walking on the sidewalk.

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.)

See attached

Page 4A

Legal Entity Representative

Margo McCarty — Signature

Margo McCarty Executive Director — Printed Name and Title

4/2/2020 — Date

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Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented

☐ Not Implemented

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100.a.

- The four-inch drop from the sidewalk to the ground at the courtyard sidewalk by the rear porch of the Mount Hope cottage was corrected by the Landscaper and Building Services Coordinator 3/16/20.
  Attachment: Picture of corrected area

- The Executive Director and Building Services Coordinator audited the walking paths on 3/11/20 for any other drops in heights and addressed, as needed.
  Attachment: Monthly Daily Rounds with statement in notes section dated and signed by the Executive Director and Building Services Coordinator.

- The Building Services Coordinator will complete rounds twice per week to audit the walking paths for any drops in the heights for the next three months, beginning 3/11/20.
  Audit tools will be available for survey review.

- The Building Services Coordinator was in-serviced regarding regulation 100.a. and the Rounds by the Executive Director on 3/12/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020

102i - Soap Dispenser

Regulations

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There are two shower rooms in the Stoy cottage. One of the shower rooms contained 3 unlabeled bars of soap stacked in the soap dish inside the shower and the other shower room had one unlabeled bar of soap in the soap dish inside the shower.

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.)

See Attached Page 5A

Legal Entity Representative

Margie McCarty — Signature

Margie McCarty Executive Director — Printed Name and Title

4/2/2020 — Date

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Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented

☐ Not Implemented

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

102.i.

- The unlabeled bars of soap were immediately removed from Stoy cottage shower rooms on 2/19/20 by the Executive Director and disposed.

- The Resident Services Supervisor or designee will conduct rounds twice per week to ensure unlabeled soap is not left in the shower room for the next three months, beginning 3/13/20. Audit tools will be available for survey review.
  Attachment: Resident Services Supervisor House Rounds Checklist

- Staff was in-serviced regarding regulation 102.i. on 2/26/20 by the Executive Director.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/20

103g - Storing Food

Regulations

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A plastic bag containing frozen waffles was stored in the Mt. Hope cottage's freezer. The plastic bag was open on one end and not completely sealed .

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.)

See Attached Page 6A

Legal Entity Representative

Margie McCarty | Margie McCarty Executive Director 4/6/2020

Signature | Printed Name and Title | Date

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Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented
☐ Not Implemented

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

103.g.

- The plastic bag containing frozen waffles stored in the Mt. Hope cottage's freezer was removed and disposed of immediately on 2/19/20 by the Executive Director.

- The Resident Services Supervisor or designee will conduct rounds twice per week to ensure all food is stored properly for the next three months, beginning 3/13/20.
  Audit tools will be available for survey review.
  Attachment: Resident Services Supervisor House Rounds Checklist

- Staff was in-serviced regarding regulation 103.g. on 2/26/20 by the Executive Director.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020

121a - Unobstructed Egress

Regulations

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 2/19/2020, in the Stoy cottage dining room, there was a dining room table with a chair of the table located in close proximity to the exit door that created an obstruction to the egress.

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.)

See Attached Page 6A

Legal Entity Representative

Margie McCarty — Signature

Margie McCarty Executive Director — Printed Name and Title

4/6/2020 — Date

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

The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

☒ Implemented

☐ Not Implemented

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

121.a.

- The dining room table chair was moved away from the exit door to eliminate an obstruction to the egress immediately on 2/19/20 by the Executive Director.

- The Building Services Coordinator will complete rounds twice per week to audit that hallways, doorways, passageways and egress routes from the building are unobstructed for the next three months, beginning 3/13/20.
  Audit tools will be available for survey review.
  Attachment: Monthly Daily Rounds

- Staff was in-serviced regarding regulation 121.a. by the Executive Director on 2/26/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/20/20

125a - Combustible Storage

Regulations

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

The plastic protector at the tip of a mop handle was in contact with the side of the hot water heater in the Stoy cottage.

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.)

See Attached Page 7A

Legal Entity Representative

Signature: Margie McCarty

Printed Name and Title: Margie McCarty Executive Director

Date: 4/2/2020

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

The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

125.a.

- The mop was moved from the side of the hot water heater in the Stoy cottage immediately on 2/19/20 by the Building Services Coordinator.

- The Building Services Coordinator will complete rounds twice per week to audit that combustible and flammable materials are not located near heat sources or hot water heaters for the next three months, beginning 3/13/20.
  Audit tools will be available for survey review.
  Attachment: Monthly Daily Rounds

- Staff was in-serviced regarding regulation 125.a. by the Executive Director on 2/26/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020

185a - Implement Storage Procedures

Regulations

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

On 2/19/2020 at 8:01am, the glucometer of Resident #1 had a blood sugar reading of 158 stored in it. This measurement was incorrectly documented on the medication administration record as 154.

On 2/18/2020 at 10:32am, the glucometer of Resident #1 had a blood sugar reading of 284 stored in it. This measurement was incorrectly documented on the medication administration record as 286.

The Toujeo Solostar insulin pen prescribed for Resident #4 directs that the medication is good for 28 days. The home has not implemented a tracking system to identify when the medication must be discarded, as the pen was not dated with the date it was initially opened or the date it should be discarded.

Repeat violation 3/27/2019

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.)

See Attached Pages 9A and 9B

Legal Entity Representative

Margie McCarty — Signature
Margie McCarty Executive Director — Printed Name and Title
4/2/2020 — Date

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The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented
☐ Not Implemented

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

185.a.

- All LPN's were in-serviced by the Executive Director on accurate documentation and following safe storage, access, security, distribution and use of medications and medical equipment by trained staff, regulation 185.a, on 3/23/20.
  Attachment: In-service attendance record

- The Toujeo Solastar pen prescribed for Resident #4 was replaced 2/19/20.
  Attachment: Proof of replacement

- The Resident Services Supervisor or designee will audit the Medication Carts weekly to ensure the medications are labelled correctly, i.e. date opened and date for discard, for the next three months, beginning 3/23/20.
  Audit tools will be available for survey review.
  Attachment: Medication Cart Audit

- Going forward, the Resident Services Coordinator or designee will attest to the accuracy of the Medication Cart Audit by completing random audits and signing the audit tool as well.
  Audit tools will be available for survey review.

Margie McCarty Executive Director
Margie McCarty 4/2/2020

Addendum 185a:

The Resident Services Supervisor will audit the actual readings on a resident's glucometer as compared with the documented readings on the resident's Medication Administration Record. This shall be done on a weekly basis for the residents who receive blood glucose testing and shall consist of a review of all readings for the previous week. The weekly audits shall occur for a period of two weeks to be completed by 4/24/20, and then randomly to ensure on-going compliance.

Attachment: Medication Cart Audit

Margie McCarty Executive Director

Margie McCarty 4/6/2020

Amended page for POC sent 4/3/2020

227g -Support Plan Signatures

Regulations

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The support plan developed for Resident #2 on 10/1/2019 was not signed by the resident or document the resident's inability or refusal to sign.

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.)

See Attached Page 10A

Legal Entity Representative

Margie McCarty — Signature

Margie McCarty Executive Director — Printed Name and Title

4/2/20 — Date

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

The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

XX Implemented

☐ Not Implemented

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

227.g.

- Resident #2 signed the support plan on 2/20/20 .
  Attachment: Resident #2's signed support plan

- All support plans will be audited by the Executive Director or designee to ensure the individuals who participated in the development of the support plan signed and dated the support plan by 4/30/20.

- The Executive Director or designee will audit all new support plans for signature for the next three months, beginning 3/23/20, to ensure compliance with regulation 227.g.

- The coordinators were in-serviced by the Executive Director regarding regulation 227.g on 3/20/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020

233c - Key-Locking Devices

Regulations

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

-On 2/19/2020, the directions for operating the home's locking mechanism posted near the exit gate of the Mount Hope Secure Dementia Care Unit (SCDU) courtyard did not provide the correct code.

-On 2/19/2020, the directions for operating the home's locking mechanism were not conspicuously posted near the exit door by bedroom 406 door of the Tabor SDCU.

-On 2/19/2020, the directions for the operation of locking mechanism for the exit door in the Tabor SDCU's living room area were located a distance of approximately 10 feet from the exit on the wall of the adjoining hallway.

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.)

See attached Pages 11A and 11B

Legal Entity Representative

Margie McCarty
Signature

Margie McCarty Executive Director 4/2/2020
Printed Name and Title Date

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

The above plan of correction is approved as of 4/6/2020 (Date)

Plan of correction implementation status as of 5/6/2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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

233.

- The directions for operating the home's locking mechanism will be conspicuously posted near the device has been corrected in the following manner: Exit gate of the Mount Hope SDCU – correct code posted; exit door by bedroom 406 of the Tabor SDCU – directions conspicuously posted near door; directions for the operation of the locking mechanism for the exit door in the Tabor SDCU's living room – posted behind on the wall.
  Attachment: photos

- Building Services Coordinator will complete rounds twice per week to audit that the directions for operating the home's locking mechanism is conspicuously posted near the device for the next three months, beginning 3/13/20.
  Audit tools will be available for survey review.
  Attachment: Monthly Daily Rounds

- Staff was in-serviced regarding regulation 233.c. by the Executive Director on 3/12/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020

Addendum 233C. directions for the operation of the locking mechanism for the exit door and the location of keypad were posted next to the Tabor SDCU exit door.

Attachment: Sign

Margie McCarty Executive Director

Margie McCarty 4/6/2020

Amended page from POC sent 4/3/2020

234a - Admission Support Plan

Regulations

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident #3's initial support plan, for the admission into the Secured Dementia Care Unit, was developed on 11/18/19, more than 72 hours after the resident's admission into the unit.

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.)

See Attached Page 12A

Legal Entity Representative

Margie McCarty — Signature

Margie McCarty Executive Director — Printed Name and Title

4/2/2020 — Date

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Plan of correction implementation status as of 5/6/2020 (Date)

XX ☒ Implemented

☐ Not Implemented

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234.a.

- Support plans will be audited by the Executive Director or designee to ensure they were completed within 72 hours of admission or within 72 hours prior to the resident's admission to the SCDU by 4/30/20.

- The Executive Director or designee will audit all new support plans re. time-frame requirement, beginning 3/23/20, to ensure compliance with regulation 234.a.

- The coordinators were in-serviced by the Executive Director regarding regulation 234.a. on 3/20/20.
  Attachment: In-service attendance record

Margie McCarty Executive Director
Margie McCarty 4/2/2020