Sent via email to: legalhelp@enlivant.com
MAILING DATE: December 14, 2020

Mr. Michael L. Costa
President and Chief Executive Officer
Williamsport AID II OPCO LLC
330 North Wabash Avenue, Suite 3700
Chicago, Illinois 60611

RE: Leighton Place
1251 Rural Avenue
Williamsport, Pennsylvania 17701
License #: 226600

Dear Mr. Costa:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 13, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Anne Graziano
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *LEIGHTON PLACE*
License Number: *22660*
Address: *1251 RURAL AVENUE,, WILLIAMSPORT, PA 17701*
County: *LYCOMING*
Region: *NORTHEAST*

Administrator

Name: *Steven Richard*
Phone: *5703221125*
Email: *ALCLICENSE@ENLIVANT.COM*

Legal Entity

Name: *WILLIAMSPORT AID II OPCO LLC*
Address: *330 N WABASH AVENUE,SUITE 3700, CHICAGO, IL, 60611*

Certificate(s) of Occupancy

Type: *C-2 LP*
Date: *08/28/2002*
Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *54*
Waking Staff: *41*

Inspection

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

Inspection Dates and Department Representative

03/13/2020 - On-Site: Jason Harvey, Corey Pica

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65*
Residents Served: *47*

Secured Dementia Care Unit

In Home: *No*
Area:
Capacity:
Residents Served:

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *46*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *7*
Have Physical Disability: *1*

29a SOPa Hospice Care: Residents Receiving Hospice Service

Regulations

2600.
29.a.a. If a personal care home elects to provide assistance with IADLs or ADLs for a resident who receives hospice care and services in accordance with § 2600.29 (relating to hospice care and services), the home shall provide for the resident's personal care needs, as well as meet the needs directed by the hospice agency for the time period that hospice service staff are not physically present in the home, and in accordance with the resident's medical evaluation, assessment and support plan.

Description of Violation

Resident #1 is currently actively dying while receiving hospice services. The home failed to provide a doctor's certification, informed consent, fire drill simulation, sufficient staff for a safe evacuation and updating the resident assessment support plan with a blueprint for safe evacuation plan. Resident #1 is actively dying and not being evacuated since December 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.)

1. Residents including actively dying hospice residents will be evacuated for fire drills unless proper documentation is in place for a dying hospice patient to stay in their room.
2, The current list of hospice patients has been reviewed and plans made for safe evacuation. Fire drills will be audited monthly for the next three months for compliance by ED or designee. Fire Drill Audit tool Attached.
3. Current staff will be educated on the Hospice requirements of 2600.29a Hospice care and services by 4/1/20 and will be reviewed at monthly staff meetings for three months. Hospice fire drill education attached.
4. Fire drills and results of audits will be reviewed in monthly QI for three months. Continued auditing will be based on sustained compliance for three months. Monitoring will be ongoing.

Legal Entity Representative

Signature | Steven Richard — Printed Name and Title | 3/27/20 — Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

Plan of correction implementation status as of 6-25-2020 (Date)

X Implemented
Not Implemented

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

103g - Storing Food

Regulations

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

Type text here

Description of Violation

2 containers of ice cream were opened and unsealed in the home's kitchen.

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.)

1. The two containers of Ice cream were sealed during licensing inspection. Dining manager reeducated dining staff regarding food storage.
2. ED or designee will 2 times per week for 12 weeks audit freezers and refrigerators for unsealed items. Kitchen Audit tool attached.
3. Current staff will be re-educated by ED or designee as part of written staff communication / In-service on proper food storage including storage in sealed containers by 4/1/2020 See attached Food Storage Education.
4. Results of audit will be reviewed in monthly QI for three months. Continued auditing will be based on sustained compliance for 3 months. Monitoring will be ongoing.

Legal Entity Representative

Signature: [signature]
Printed Name and Title: Steven Richard, ED
Date: 3/27/20

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

The above plan of correction is approved as of 3-27-2020 (Date)

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

Plan of correction implementation status as of 6-25-2020 (Date)

[X] Implemented
[ ] Not Implemented

132a - Monthly Fire Drill

Regulations

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of March 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.)

1. March 2019 missed fire drill cannot be corrected, but unannounced fire drills are being conducted monthly by current management team.
2. The ED or designee will be responsible to audit monthly for the next three months to see that fire drills are conducted monthly and properly documented per regulation 2600.132.a. . Fire Drill audit tool attached.
3. Current Maintenance Technician will be educated by the ED on requirements and documentation for monthly fire drills by April 1, 2020. Fire drill education is attached.
4. QI to remain complaint - Documentation of the fire drills will be reviewed in monthly QI for three months. Continued review will be based on sustained compliance for three months. Monitoring will be ongoing by ED.

Legal Entity Representative

Signature | Steven Richard, ED — Printed Name and Title | 3/27/20 — Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

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

Plan of correction implementation status as of 6-25-2020 (Date)

[X] Implemented
[ ] Not Implemented

132c - Fire Drill Records

Regulations

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 records for the drills conducted on 12/26/19, 1/29/20 and 2/29/20 does not include the correct number of residents who evacuated. Resident #1 is actively dying and did not evacuate, but the fire drill log indicated that resident #1 did evacuate.

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.)

1. Residents will be evacuated unless proper documentation is in place for an actively dying hospice patient to stay in their room.
2. Fire drill records will be audited monthly for three months by ED or designee for proper recording of the number of residents evacuated and proper accounting of any Hospice patient not evacuated. Fire drill audit tool attached.
3. QI to remain compliant - Documentation of the fire drills will be reviewed in monthly QI for three months. Continued review will be based on sustained compliance for three months. Monitoring will be ongoing by ED.

Legal Entity Representative

Signature

Steven Richard, ED — Printed Name and Title

3/27/20 — Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

Plan of correction implementation status as of 6-25-2020 (Date)

X Implemented

☐ Not Implemented

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

132h - Designated Meeting Place

Regulations

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 12/26/19, 1/28/20 and 2/29/20 resident #1 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

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.)

1. Residents will be evacuated unless proper documentation is in place for an actively dying hospice patient to stay in their room.
2. Fire drill records will be audited monthly for three months by ED or designee for proper recording of the number of residents evacuated and proper accounting of any Hospice patient not evacuated. Fire drill audit tool attached.
3. QI to remain compliant - Documentation of the fire drills will be reviewed in monthly QI for three months. Continued review will be based on sustained compliance for three months. Monitoring will be ongoing by ED.

Legal Entity Representative

Signature

Steve Richard, ED 3/22/20

Printed Name and Title Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

Plan of correction implementation status as of 6-25-2020 (Date)

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

[X] Implemented
[ ] Not Implemented

187a - Medication Record

Regulations

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 7 mg of Oseltamivir. However, resident #2's medication administration record does not indicate a diagnosis or purpose.

Resident #3 is prescribed 100 mg Xarelto and 7 mg of Clopidogrel. However, resident #3's medication administration record does not indicate a diagnosis or purpose.

REPEATED VIOLATION 3-19-2019

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.)

1. Resident #2 and #3 records corrected in the presence of the DOH Auditor on 3/13/20 to indicate a diagnosis or purpose.
2. The CSM or designee will complete 5 MAR audits weekly x three months to ensure compliance. Audit tool attached.
3. CSM was re-educated by Regional Nurse on March 25, 2020 and Med techs will be re-educated by April 1, 2020 to ensure medication orders include a diagnosis or purpose.
4. The results of audits will be reviewed in monthly QI. Continued auditing will be based on sustained compliance for three months. Monitoring will be on-going.

Legal Entity Representative

Signature

Steven Richard
Printed Name and Title

3/27/20
Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

Plan of correction implementation status as of 6-25-2020 (Date)

X Implemented
Not Implemented

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

227d - Support Plan Medical/Dental

Regulations

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #1's assessment support plan dated 11/2/19 does not indicate that the resident is currently receiving hospice services and who will meet the resident's needs.

REPEATED VIOLATION 3-19-2019

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.)

1. Resident #1 support plan was corrected on 3/13/20 with a RASP addendum to include hospice.
2. The Executive Director and/or designee will audit resident RASPs for residents who have hospice monthly for three months to ensure compliance. RASP Audit tool attached
3. CSM was re-educated by Regional Nurse on March 25, 2020 on services to be documented on RASP.
4. QI to remain compliant - The results of audits will be reviewed in monthly QI X 3 months. Continued auditing will be based on sustained compliance for three months. Monitoring will be on-going

Legal Entity Representative

Signature

Steven Richard
Printed Name and Title

3/27/20
Date

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

The above plan of correction is approved as of 3-27-2020 (Date)

Plan of correction implementation status as of 6-25-2020 (Date)

X Implemented
Not Implemented

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