

Department of Human Services
Bureau of Human Service Licensing

October 16, 2020

MICHAEL L COSTA, PRESIDENT/CHIEF EXECUTIVE OFFICER
WILLIAMSPORT AID II OPCO LLC
330 N WABASH AVENUE,SUITE 3700
CHICAGO, IL 60611

RE: LEIGHTON PLACE
1251 RURAL AVENUE
WILLIAMSPORT, PA, 17701
LICENSE/COC#: 22660

Dear Mr. Costa,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/21/2020, 07/22/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Anne Graziano

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: *LEIGHTON PLACE* License #: *22660* License Expiration Date: *05/15/2021*
 Address: *1251 RURAL AVENUE, WILLIAMSPORT, PA 17701*
 County: *LYCOMING* Region: *NORTHEAST*

Administrator

Name: *Steven Richard* Phone: *5703221125* Email:
srichard@enlivant.com; lindscott@pa.gov;
agraziano@pa.gov

Legal Entity

Name: *WILLIAMSPORT AID II OPCO LLC*
 Address: *330 N WABASH AVENUE, SUITE 3700, CHICAGO, IL, 60611*
 Phone: *5703221125* Email: *LEGALHELP@ENLIVANT.COM*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *50* Waking Staff: *38*

Inspection

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *07/21/2020*

Inspection Dates and Department Representative

07/21/2020 - On-Site: Ryan Yankowy
07/22/2020 - Off-Site: Ryan Yankowy

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* Residents Served: *45*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *45*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *5* Have Physical Disability: *0*

Inspections / Reviews

07/21/2020 - Partial

Lead Inspector: *Ryan Yankowy*Follow-Up Type: *POC Submission*Follow-Up Date: *08/17/2020*

9/16/2020 - POC Submission

Lead Reviewer: *Anne Graziano*Follow-Up Type: *Document Submission*Follow-Up Date: *10/01/2020*

10/16/2020 - Document Submission

Lead Reviewer: *Anne Graziano*Follow-Up Type: *Not Required*

5a1 - DHS Access

1. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

- 1. Agents of the Department.

Description of Violation

The home did not have access to the employee records on 7/21/20 due to not having the key to the filing cabinet. Licensing representative requested the homes internal investigation for the incident dated 7/13/20. The Administrator reported that they were unable to be given to this writer until their legal department reviewed it. This writer did not have immediate access to the records.

Plan of Correction

Directed

Please see attached

Directed Plan of Correction:

The home will retain the audits referenced in attachment # 1. The location and accessibility of the key will also be checked by the Adm. audit reviews and Monthly QI results will also be retained by the Home. AG

Completion Date: 10/01/2020

Update - 09/03/2020

Document Submission

Implemented

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

The administrator or a designee shall provide, upon request, immediate access to the home, the residents and the records to all state entities providing oversight to the community.

Leighton Place will relocate the storage area for all employee records to a centrally located office by 8/17/2020 that will allow accessibility to the Executive Director (ED) and the designee without delays. The Executive Director (ED) and designee will have a key available for access.

Executive Director (ED) and designee were re-educated on the anticipated new location of employee files and the need to provide, upon request, immediate access to state entities. Re-education was completed by Regional Care Specialist on 8/12/20. (See attachment #1)

The Executive Director (ED) and designee will audit weekly X4 months and then monthly X2 for the key location and availability. (See attachment #2)

These audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance. The home will retain the completed audits referenced in attachment #1. Audit review and QI results (Attachment #6) will be retained by the facility.

15a - Resident Abuse Report

1. Requirements

2600.

15a - Resident Abuse Report (continued)

- 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 Violation

Direct care staff member A made an allegation of abuse against Staff member B and the treatment of Resident #1 on 7/11/20, the home did not report the allegation of abuse to the local area agency on aging.

Plan of Correction**Directed**

Please see attached

Directed Plan of Correction:

9-16-2020

In order to be compliant with Regulations 2600.15a, 15b, 15d and 16c, the home will need to ensure that the Regional Director of Care Services, the Administrator and/or the Care Services Manager will have the ability to oversee that daily incident reporting is reviewed and acted upon by a trained person. That person must then have the authority to submit Incident Reports to the Northeastern Regional Office and to act upon allegations of abuse of residents and make staffing decisions that affect resident safety immediately.

Completion Date: *09/16/2020*

15a - Resident Abuse Report (continued)

Document Submission**Implemented**

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

The incident regarding resident #1 and the alleged rough handling that occurred on 7/11/2020 was reported to the Departments regional office on 7/17/2020. Staff member B was put on suspension on 7/16/2020 pending an internal investigation.

ED and/or designee completed an audit on 7/21/2020 of current residents that have increased care needs to identify any other potential concerns. No other concerns were noted that required reporting to the state. (See attachment #3) Executive Director (ED), Care Services Manager (CSM) and Business Office Manager (BOM) were re-educated on reportable incidents specified in 2600.16A and state requirement of reporting these incidents within 24 hours as per 2600.16C, including abuse. Education on immediate internal investigation and suspension of employee(s) involved in alleged abuse pending investigation. This training was completed on 7/23/2020 by Regional Care Services. (See attachment #4). Additional education was provided on 8/24/20 and 9/22/20 regarding abuse and incident reporting policies and regulatory requirements. (See attachment #4).

ED or CSM will review incident reports weekly x4 and then monthly x2 to ensure that state requirements have been met for abuse reporting. (See attachment #6).

Current staff including the Executive Director (ED) and Care Service Manager (CSM) received training on abuse, resident rights, 24 hour reporting requirements and transfers. Training completed on 7/23/2020 by Regional Care Specialist and Residential Home Care. (See attachment #4). The Regional Care Specialist revised the reporting procedures requiring written state reportable forms be completed by all on-call Care Service Managers. The Executive Director/designee will be notified of all incidents at the time of the incident by the facility employees. The Executive Director/designee will give instruction to employees how to respond to the incident and report as necessary to the proper agencies. Executive Director/Designee will maintain copies of all IR's and maintain a running audits of reportable incidents (attachment #5)

These Audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance.

15b - Supervisor Plan

1. Requirements

2600.

- 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

An allegation of abuse was made regarding Direct care staff member B on 7/11/20, the home did not suspend the staff member until 7/16/20.

15b - Supervisor Plan (continued)

Plan of Correction

Directed

Please see attached

Directed Plan of Correction

9-16-2020

In order to be compliant with Regulations 2600.15a, 15b, 15d and 16c, the home will need to ensure that the Regional Director of Care Services, the Administrator and/or the Care Services Manager will have the ability to oversee that daily incident reporting is reviewed and acted upon by a trained person. That person must then have the authority to submit Incident Reports to the Northeastern Regional Office and to act upon allegations of abuse of residents and make staffing decisions that affect resident safety immediately.

Completion Date: 09/16/2020

Document Submission

Implemented

The incident regarding resident #1 and the alleged rough handling that occurred on 7/11/2020 was reported to the Departments regional office on 7/17/2020. Staff member B was put on suspension on 7/16/2020 pending an internal investigation.

ED and/or designee completed an audit on 7/21/2020 of current residents that have increased care needs to identify any other potential concerns. No other concerns were noted that required reporting to the state. (See attachment #3) Executive Director (ED), Care Services Manager (CSM) and Business Office Manager (BOM) were re-educated on reportable incidents specified in 2600.16A and state requirement of reporting these incidents within 24 hours as per 2600.16C, including abuse. Education on immediate internal investigation and suspension of employee(s) involved in alleged abuse pending investigation. This training was completed on 7/23/2020 by Regional Care Services. (See attachment #4). Additional education was provided on 8/24/20 and 9/22/20 regarding abuse and incident reporting policies and regulatory requirements. (See attachment #4).

ED or CSM will review incident reports weekly x4 and then monthly x2 to ensure that state requirements have been met for abuse reporting. (See attachment #6 and #10).

Current staff including the Executive Director (ED) and Care Service Manager (CSM) received training on abuse, resident rights, 24 hour reporting requirements and transfers. Training completed on 7/23/2020 by Regional Care Specialist and Residential Home Care. (See attachment #4). The Regional Care Specialist revised the reporting procedures requiring written state reportable forms be completed by on-call Care Service Managers. The Executive Director/designee will be notified of all incidents at the time of the incident by the facility employees. The Executive Director will give instruction to employees how to respond to the incident and report as necessary to the proper agencies. Executive Director/Designee will maintain copies of all IR's and maintain a running audits of reportable incidents (attachment #5and 5-2)

These Audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance.

Update - 10/16/2020

Update

10-16-2020, AG, RLA

Supervised Plans for staff that remain working after an allegation of abuse, neglect, exploitation or abandonment must be approved by the Northeastern Regional Office. the home must maintain evidence of that approval.

15d - Resident Abuse-Notification

1. Requirements

2600.

15d - Resident Abuse-Notification (continued)

15.d. The home shall immediately notify the resident and the resident's designated person of a report of suspected abuse or neglect involving the resident.

Description of Violation

Resident #1's designated person was not notified regarding an allegation of abuse until 7/16/20. The allegation of abuse was made on 7/11/20.

Plan of Correction**Directed**

Please see attached

Directed Plan of Correction

9-16-2020

In order to be compliant with Regulations 2600.15a, 15b, 15d and 16c, the home will need to ensure that the Regional Director of Care Services, the Administrator and/or the Care Services Manager will have the ability to oversee that daily incident reporting is reviewed and acted upon by a trained person. That person must then have the authority to submit Incident Reports to the Northeastern Regional Office and to act upon allegations of abuse of residents and make staffing decisions that affect resident safety immediately.

Completion Date: *09/16/2020*

Document Submission**Implemented**

The incident regarding resident #1 and the alleged rough handling that occurred on 7/11/2020 was reported to the Departments regional office on 7/17/2020. Staff member B was put on suspension on 7/16/2020 pending an internal investigation.

ED and/or designee completed an audit on 7/21/2020 of current residents that have increased care needs to identify any other potential concerns. No other concerns were noted that required reporting to the state. (See attachment #3) Executive Director (ED), Care Services Manager (CSM) and Business Office Manager (BOM) were re-educated on reportable incidents specified in 2600.16A and state requirement of reporting these incidents within 24 hours as per 2600.16C, including abuse. Education on immediate internal investigation and suspension of employee(s) involved in alleged abuse pending investigation. This training was completed on 7/23/2020 by Regional Care Services. (See attachment #4). Additional education was provided on 8/24/20 and 9/22/20 regarding abuse and incident reporting policies and regulatory requirements. (See attachment #4).

ED or CSM will review incident reports weekly x4 and then monthly x2 to ensure that state requirements have been met for abuse reporting. (See attachment #8).

Current staff including the Executive Director (ED) and Care Service Manager (CSM) received training on abuse, resident rights, 24 hour reporting requirements and transfers. Training completed on 7/23/2020 by Regional Care Specialist and Residential Home Care. (See attachment #4). The Regional Care Specialist revised the reporting procedures requiring written state reportable forms be completed by on-call Care Service Managers. The Executive Director/designee will be notified of all incidents at the time of the incident by the facility employees. The Executive Director/designee will give instruction to employees how to respond to the incident and report as necessary to the proper agencies. Executive Director/Designee will maintain copies of all IR's and running audits of reportable incidents (attachment #5 and 5-2)

These Audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance.

15d - Resident Abuse-Notification (*continued*)**Update - 10/16/2020***Update:**10-16-2020**AG, RLA*

This specific regulation requires that the designated person also be notified of a resident being named the subject of the allegation of abuse, abandonment, exploitation or neglect. Please ensure that the home's policy is adjusted to include this regulatory information and that managerial/administrative staff are following up to ensure that it is acted upon. If necessary, please provide updated training to include this step.

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).

Description of Violation

Direct care staff member A made an allegation of abuse against Staff member B and the treatment of Resident #1 on 7/11/20, the home did not report the allegation of abuse to the Department until 7/17/20.

Plan of Correction**Directed***Please see attached**Directed Plan of correction**9-16-2020*

In order to be compliant with Regulations 2600.15a, 15b, 15d and 16c, the home will need to ensure that the Regional Director of Care Services, the Administrator and/or the Care Services Manager will have the ability to oversee that daily incident reporting is reviewed and acted upon by a trained person. That person must then have the authority to submit Incident Reports to the Northeastern Regional Office and to act upon allegations of abuse of residents and make staffing decisions that affect resident safety immediately.

In addition, The administrator will ensure that all employees of the home are trained in the other 18 events that are reportable under 16a. Evidence of training will be submitted with the follow-up Plan of Correction no later than 2 weeks from the return of this Plan of Correction.

Completion Date: *10/01/2020*

16c - Written Incident Report *(continued)***Document Submission****Implemented**

The incident regarding resident #1 and the alleged rough handling that occurred on 7/11/2020 was reported to the Departments regional office on 7/17/2020. Staff member B was put on suspension on 7/16/2020 pending an internal investigation.

ED and/or designee completed an audit on 7/21/2020 of current residents that have increased care needs to identify any other potential concerns. No other concerns noted that required reporting to the state. (See attachment #3). Current staff including Executive Director (ED) and Care Service Manager (CSM) were re-educated on reportable incidents specified in 2600.16A and the state requirement of reporting these incidents within 24 hours as per 2600.16C including abuse. This training was completed by the Regional Director of Care Services and Regional Care Specialist on 7/23/2020. Employees were in-service on 8/24/20 and 9/22/20 regarding abuse and incident reporting policies and regulatory requirements including training on the 18 events that are reportable under regulation 16(a). (See attachment # 4) The Executive Director/designee will be notified of all incidents at the time of the incident by the facility employees. The Executive Director/designee will give instruction to employees how to respond to the incident and report as necessary to the proper agencies. Executive Director/Designee will maintain copies of all IR's and maintain a running audits of reportable incidents (attachment #5)

ED or CSM will review incident reports weekly x4 and then monthly x2 to ensure that state requirements have been met for abuse reporting. (See attachment #7).

These Audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance.

42c - Treatment of Residents

1. Requirements

2600.

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

Description of Violation

It has been determined through staff and resident interviews that Direct care staff member B can be very pushy with the residents and rush them during care when the residents are not comfortable with the pace of care being provided. Direct care staff member B is not treating the residents with dignity and respect.

Plan of Correction**Directed**

Please see attached

Directed Plan of Correction

9-16-2020

The home will submit the last 2 months of QI Resident Surveys related to Resident Rights awareness/Satisfaction with the Plan of Correction attachments for Review to the Northeastern Regional Office. QI documents related to Resident Rights will be retained by the home.

AG

Completion Date: 10/01/2020

42c - Treatment of Residents (*continued*)**Document Submission****Implemented**

The incident regarding resident #1 and the alleged rough handling that occurred on 7/11/2020 was reported to the Departments regional office on 7/17/2020. Staff member B was put on suspension on 7/16/2020 pending an internal investigation.

ED and/or designee completed an audit on 7/21/2020 of current residents that have increased care needs to identify any other potential concerns. No other concerns were noted that required reporting to the state. The current Executive Director and Life Enrichment Coordinator conducted resident interviews with all current residents. All employees were in-service on 8/24/20, 9/22/20, 9/24/2020 regarding resident rights including treating residents with dignity and respect (See attachment #3).

Current staff including the Executive Director (ED) and Care Service Manager (CSM) were re-educated on resident rights as per 2600.42. This training was completed by the Regional Director of Care Services and Regional Care Specialist on 7/23/2020. (See attachment #4).

ED or CSM will audit residents with increased level of care weekly X4 then monthly X2 to ensure residents are being treated with dignity and respect. (See attachment #6 and #10).

These Audits will be reviewed at the monthly QI. Continued review will be based on 3 months of sustained compliance.