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

November 28, 2023

[redacted], ADMINISTRATOR
MORAVIAN MANORS INC
300 WEST LEMON STREET
LITITZ, PA, 17543

RE: MORAVIAN MANOR
300 WEST LEMON STREET
LITITZ, PA, 17543
LICENSE/COC#: 33309

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/06/2023, 09/07/2023, 09/08/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *MORAVIAN MANOR* **License #**: *33309* **License Expiration**: *01/01/2024*

Address: *300 WEST LEMON STREET, LITITZ, PA 17543*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *MORAVIAN MANORS INC*

Address: *300 WEST LEMON STREET, LITITZ, PA, 17543*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *R-4* **Date**: *09/13/2017* **Issued By**: *Lititz Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/08/2023*

Inspection Dates and Department Representative

09/06/2023 - On-Site [redacted]

09/07/2023 - On-Site

09/08/2023 - On-Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *26*

Special Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

09/06/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/28/2023*

Inspections / Reviews *(continued)*

10/10/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *10/18/2023*

11/07/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *11/14/2023*

11/28/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *11/14/2023*

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

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the assisted living residence.

Description of Violation

On 9/8/23, the residence's most recent Licensing Inspection Summary, dated 8/1/22, was not posted in a conspicuous and public place in the residence. The only LIS posted was dated 12/19/19.

Plan of Correction ***Accept [redacted] - 10/24/2023)***

Copy of the LIS from 8/1/22 was obtained on 9/25/23, by the Administrator [redacted] from DHS. The LIS was printed out and posted on the bulletin Bulletin Board on the first floor of AL, by Administrator [redacted] on 9/25/23, and a copy is also kept in the Wellness Center in a binder marked LIS 2022, placed there by the Administrator [redacted]. Monthly checks to be done to make sure LIS is still there and incase it goes missing the Administrator, [redacted] will print another one and post again. Checks are done monthly by Administrator [redacted] and they started October 1, 2023. On 9/26/23 staff were educated on the violation and where the LIS is posted and that if it goes missing, before next check, staff is to notify Administrator [redacted], to get a replacement LIS and post it. Staff was educated by Administrator Denise Geib.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented [redacted] - 11/27/2023)

22a1 Medical Eval - time frames

2. Requirements

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies

Description of Violation

Resident #1 was originally admitted to the home on [redacted]. There is no documentation of a medical evaluation (ADME) prior to 10/30/19.

Plan of Correction ***Accept ([redacted] - 10/24/2023)***

See attached.
Audit was performed 4/2023 by an outside Auditor of the 2022 ADME's. Admission Coordinator was educated on 9/25/23 by Administrator [redacted]. Admission checklist created by Administrator, [redacted] and Clinical Coordinator, [redacted] to ensure that all paperwork is received and completed and was put into place on 10/1/2023. As of 10/1/23 the Administrator, [redacted] will review all Admission checklists for completion and in the absence of the Administrator the Clinical Coordinator, [redacted], will review the Admission checklist to make sure all documentation and documents are received. This will be included in the AL monthly QAPI report.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented [redacted] - 11/27/2023)

26a Quality management plan

3. Requirements

26a Quality management plan *(continued)*

2800.
26.a. The residence shall establish and implement a quality management plan.

Description of Violation

The community as a whole has a quality management plan. However, assisted living portion of the community has not had any involvement in the reviews of these plans, nor had been included in quality management meetings.

Plan of Correction ***Accept (- 10/24/2023)***

As of 10/19/23, AL/PC Administrator, will be included in the Community QAPI meetings. Monthly report will be provided in the QAPI meeting, by the Administrator . Report to included number of admissions, any errors with admission, number of falls, number of reportables, medication errors, staff trainings, discussions from Resident Council meetings, any complaints and any Licensing violations and corrections.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented - 11/27/2023)

54a Direct care staff quals

4. Requirements

2800.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff persons A and B do not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept - 10/24/2023)***

See attached.
Human Resources was given a copy of regulation 54.a and educated on 9/13/23 regarding the requirements that ALL Direct Care Staff must produce a copy or original of their diploma or GED to be kept in their employment file. The education was provided by the Administrator, . The exception being any licensed staff such as CNA or LPN/RN with an active license. This violation was corrected on 9/19/23 when both employees were able to provide their diplomas and were added to their employee file. This has been added to the new hire paperwork checklist as of 9/18/23 by Administrator . All files have been reviewed and there were no other documents missing, because all other staff are either LPN's or CNA's. This was completed on 9/18/23 by Administrator and Human Resource Director .

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented - 11/27/2023)

63a First Aid/CPR 1:35

5. Requirements

2800.
63.a. For every 35 residents, there shall be at least one staff person trained in first aid and certified in obstructed airway techniques and CPR present in the residence at all times to meet the needs of the residents.

Description of Violation

At all of dates and time listed below, there were 26 residents in the Assisted Living Residence. For these dates and times, the residence did not have anyone working who was trained in first aid and certified in obstructed airway

63a First Aid/CPR 1:35 (continued)

techniques and CPR.

8/13/23 from 3:15 PM to 11:00 PM
8/16/23 from 4:30 PM to 11:00 PM
8/17/23 from 4:30 PM to 11:00 PM
8/21/23 from 4:30 PM to 11:00 PM
8/22/23 from 4:30 PM to 11:00 PM.

Plan of Correction ***Accept (- 10/24/2023)***

A nurse has been added to the 2nd shift staffing until all staff, that is missing First Aid, can be trained in First Aid. The next class we could get was 11/13/2023 from 1430-1630. Education was provided to the Nursing Assistant, who schedules the staff for the CPR/First Aid Training. She was provided with a copy of the regulation that states all staff need CPR/First Aid Training. Nursing Assistant, , has provided the Administrator , with a copy of the tracking sheet for expiration of CPR/First Aid. Administrator, , does the weekly schedules and has been making sure that for every 35 residents there is a staff member trained in CPR/First Aid on for every shift.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented - 11/27/2023)

65g Initial direct care training

6. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff persons A and B, hired on and respectively, have been providing unsupervised assisted living services. However, neither of the staff persons have completed and passed the Department-approved direct care training course and passed the competency test.

Plan of Correction ***Accept - 10/24/2023)***

All staff that are not CNA's or LPN/RN will complete the Direct Care training through Temple University. Extra staff is being scheduled so staff that need the Direct Care Training can be off the floor to complete the training. All training to be completed by end of October 2023. Staff A completed Direct Care training on 9/28/23 and Staff member B is scheduled to complete training on 10/30/23. This requirement for PCA's has been added to the new hire checklist by Administrator and Human Resources educated on the requirement and a copy of the Regulation provided to , Director of Human Resources on 9/13/23.

65g Initial direct care training *(continued)*

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 11/27/2023)

66c Traning plan documentation

7. Requirements

2800.
66.c. Documentation of compliance with the staff training plan shall be kept.

Description of Violation

The home has a staff training plan in place for 2023. However, the monthly trainings ceased in April 2023, The home has not maintained documentation of the completion of courses in the staff training plan including but not limited to infection control, POC training, falls and accident prevention, emergency preparedness and safe management techniques.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

See attached.
Attached is the training plan for the rest of 2023 and we are currently working on our training plan for 2024. The Administrator[redacted] and Clinical Coordinator, [redacted] planned the training calendar and will be responsible for the training of staff or coordinating the training by other staff that are qualified.

Licensee's Proposed Overall Completion Date: *10/31/2023*

Implemented [redacted] - 11/27/2023)

96a First aid kit

8. Requirements

2800.
96.a. The residence shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers. The residence shall have an automatic external defibrillation device located in each building on the premises.

Description of Violation

The first aid kit located in the nurse's station does not include tweezers.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
On 9/26/23 tweezers have been replaced in First Aid Kit by Clinical Coordinator, [redacted], at which time[redacted] confirmed all required items were present in the First Aid Kit. Monthly checks will be done by 3rd shift nursing staff, [redacted] or [redacted] starting 10/1/23. These checks are to done between the 1st of the month and the 5th day of the month. and Clinical Coordinator[redacted], will follow up to make sure they were completed. If anything is missing from the First Aid kit, [redacted] or [redacted] is to notify Administrator or Clinical Coordinator so items can be replaced.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented [redacted] - 11/27/2023)

132a Monthly fire drill

9. Requirements

132a Monthly fire drill *(continued)*

2800.
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 January 2023, July 2023 and August 2023.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Administrator, [redacted] and Maintenance Director, [redacted] discussed, reviewed regulation and planned the fire drills for the rest of the year and that there has to be a an unannounced fire drill in AL every month and 2 a year on 3rd shift. This was corrected on 9/20/23 when drill was held and again on 10/11/23. Whoever conducts the drill will then scan Fire Drill documents into system and email to Maintenance Director [redacted] and Administrator [redacted]. Fire Drill documents are being kept in the Fire Drill Log book in Administrators Office in date order.

Licensee's Proposed Overall Completion Date: *10/16/2023*

Implemented [redacted] - 11/27/2023)

132c Fire drill records

10. Requirements

2800.
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 residence 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 record for the drills conducted on 5/9/23 and 6/15/23 do not include time to evacuate, number of residents evacuated, number of staff evacuated, nor exit routes used.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

Previous Administrator had developed a form for fire drills, this Administrator, [redacted] reviewed regulation with Maintenance Director, [redacted] on 10/11/23. Administrator and Maintenance Director reviewed the DHS Fire Drill forms and on the next fire drill will be using the DHS fire drill forms. Administrator sent the forms electronically to Maintenance Director for [redacted] to print and utilize starting 10/11/23. All fire drill paperwork is to scanned in and forwarded to Administrator, [redacted], to reviewed to make sure forms are all completed correctly and if there is information missing to address with Maintenance Director, [redacted]. If drill is not not completely properly another drill will be done until it is completed properly.

Proposed Overall Completion Date: 10/17/2023

Licensee's Proposed Overall Completion Date: *10/17/2023*

Implemented ([redacted] - 11/27/2023)

141a Medical evaluation

12. Requirements

2800.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

141a Medical evaluation *(continued)*

11. An indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. In the event a tuberculin skin test has not been administered, the test shall be administered within 15 days after admission.

Description of Violation

The medical evaluations for Resident #2 and #3, dated [redacted] and [redacted] respectively, does not include an indication that a tuberculin skin test has been administered with negative results within 2 years; or if the tuberculin skin test is positive, the result of a chest X-ray. These areas of the forms are blank.

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
ADME tracker was created by Clinical Coordinator, [redacted] so that [redacted] can track when a resident is due for their next annual exam by their physician. As for the PPD test, we are currently trying to track down when the residents had their last done, by contacting their physician offices and checking with families. As of 10/9/23, after following up with Physicians and families, we have 7 residents that we have confirmed, during audit, that do have a current PPD, including Resident #3 that had one [redacted] electronic record updates as well as paperwork. Clinical Coordinator, [redacted] is currently trying to get orders on all residents that we can not confirm have had a PPD in the last 2 years, so they can be administered. PPD's will be administered by AL Nursing staff, Clinical Coordinator and Administrator as soon as orders are obtained. Administrator, [redacted] educated the Admissions Coordinator, [redacted] on 9/25/23. Tracking tool has been implemented on 9/25/23 and is updated after each ADME has been completed by the Clinical Coordinator, [redacted] n, who is responsible for maintaining ADME tracking tool and Administrator, [redacted] gets a copy after each update.

Licensee's Proposed Overall Completion Date: *10/17/2023*

Implemented ([redacted] - 11/27/2023)

141b1 Annual medical evaluation

13. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on [redacted]. The resident's previous medical evaluation was completed on [redacted].

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
ADME tracker was created by Clinical Coordinator, [redacted] on 9/25/23 after an audit was completed after audit was done 9/21/23-9/22/23. Tracking tool has been implemented on 9/25/23 and is updated after each ADME has been completed by the Clinical Coordinator, [redacted], who is responsible for maintaining ADME tracking tool and Administrator, [redacted] gets a copy after each update.

Licensee's Proposed Overall Completion Date: *10/17/2023*

Implemented [redacted] - 11/27/2023)

185a Storage procedures

14. Requirements

185a Storage procedures *(continued)*

2800.
185.a. The residence 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

Resident #2 is prescribed [redacted]. One tablet every 12 hours as needed. On [redacted], this medication was not available in the residence.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

See attached.
Routine medication cart audits will be completed bi-weekly, by clinic coordinator, [redacted], until medication cart audits can be done by [redacted] Pharmacy monthly. Nursing staff was educated by Administrator, [redacted] and Clinical Coordinator, [redacted], on 9/25/23 via email to Nursing staff and in person face to face conversation with Nursing staff to not confirm a medication order until medication has been received from the Pharmacy. Cart audits by Pharmacy are to start 10/2023, waiting on specific date from Pharmacy. Clinical Coordinate will then do periodic cart checks when there is a medication change to make sure discontinued medications have been removed from med cart and if there is a new medication order to make sure the new medication has arrived and been added to the medication cart. This has already been taking place since 9/28/23.

Licensee's Proposed Overall Completion Date: *10/17/2023*

Implemented ([redacted] - 11/27/2023)

186b Medication used by resident

15. Requirements

2800.
186.b. Prescription medications shall be used only by the resident for whom the prescription was prescribed.

Description of Violation

On 9/7/23, a used tube of [redacted] was found in the first aid kit in the residence. This medication had a label indicating that it belonged to a resident who was discharged from the home on [redacted]

Plan of Correction ***Accept [redacted] - 11/06/2023)***

Staff educated, by Clinical Coordinator, [redacted] and Administrator, [redacted] that prescriptions are to only be used for those that are prescribed for and when a medication is discontinued it is to be removed from the medication cart and disposed of properly or sent to pharmacy to be disposed of. Ointment in question was removed by Clinical Coordinator, [redacted] and disposed of by Administrator [redacted] and Clinical Coordinator [redacted] on 9/8/23. Resident label was removed and ointment was disposed of. Staff was educated on 9/26/23 by Administrator [redacted] and Clinical Coordinator [redacted], by review the regulation with staff and reviewing what is required in the first aid kits and who will be responsible for the monthly checks, 3rd shift nurses. Monthly first aid checks started 1st week of October by [redacted], LPN and [redacted], LPN. Periodic checks will also be done by Administrator [redacted]

Licensee's Proposed Overall Completion Date: *10/17/2023*

Implemented ([redacted] - 11/27/2023)

225a1 Assessment – annually

16. Requirements

2800.

225a1 Assessment – annually *(continued)*

225.a.1. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows: Annually.

Description of Violation

Resident # 1's most recent assessment was completed on [redacted] The previous assessments provided were dated [redacted] and [redacted]

Resident #3's most recent assessment was completed on [redacted]. The previous assessment was completed on [redacted]

Plan of Correction ***Accept ([redacted] - 11/06/2023)***

See attached.
Tracking tool created by Clinical Coordinator, [redacted] Anderson so that assessments are not missed and are completed yearly or if a significant change has occurred. Clinical Coordinator will maintain tracker and update it accordingly, and in case of [redacted] absence the Administrator shall maintain tracker. Administrator, [redacted] and Clinical Coordinator meet weekly to discuss tracker and what assessments are coming up and what is done. Management was made aware of the violation and the regulation was reviewed with them one on one. the week of 9/25/23, by Administrator [redacted].

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)

227c Final support plan - revision

17. Requirements

2800.
227.c. The final support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment. The residence shall review each resident's final support plan on a quarterly basis and modify as necessary to meet the resident's needs.

Description of Violation

Resident #1's support plan dated [redacted], has not been reviewed on a quarterly basis, the last review was completed on [redacted] However, there was no reviews completed in 2022.

Resident #2's initial support plan is dated [redacted]. However, there have been no quarterly reviews completed.

Resident #3's most recent support plan is dated [redacted]. However, there have been no quarterly reviews completed.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

See attached.
Quarterly assessment tracker was created by Clinical Coordinator, [redacted] and Administrator, [redacted] to review support plans every quarter and make note of any changes that will need to be made on the next yearly assessment or if there is a significant change that the Support Plan was changed for. Audit of AL was done the 2nd week of August 2023 and all ASP have been reviewed and placed on the tracker at that time and next review documented when due. All charts, other than the 2 new admissions have had their ASP quarterly reviews. New ASP's are to be done in December for their first quarterly review.

Licensee's Proposed Overall Completion Date: *10/18/2023*

Implemented ([redacted] - 11/27/2023)