

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

November 2, 2023

[REDACTED]
COLUMBIA WEGMAN TOWAMENCIN LLC
[REDACTED]
[REDACTED]

RE: THE LANDING AT TOWAMENCIN
900 TOWAMENCIN AVENUE
LANSDALE, PA, 19446
LICENSE/COC#: 14533

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/24/2023 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: *THE LANDING AT TOWAMENCIN* License #: *14533* License Expiration: *01/21/2024*
Address: *900 TOWAMENCIN AVENUE, LANSDALE, PA 19446*
County: *MONTGOMERY* Region: *SOUTHEAST*

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: *COLUMBIA WEGMAN TOWAMENCIN LLC*
Address: [Redacted]
Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: *I-1* Date: *09/24/2019* Issued By: *Towamencin Township*
Type: *I-2* Date: *09/24/2019* Issued By: *Towamencin Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *107* Waking Staff: *80*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Incident* Exit Conference Date: *09/07/2023*

Inspection Dates and Department Representative

08/24/2023 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* Residents Served: *68*

Secured Dementia Care Unit

In Home: *Yes* Area: *Opal* Capacity: *59* Residents Served: *32*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *68*
Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *39* Have Physical Disability: *1*

Inspections / Reviews

08/24/2023 - Partial

Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *10/02/2023*

10/31/2023 - POC Submission

Submitted By: [Redacted] Date Submitted: *11/01/2023*
Reviewer: [Redacted] Follow-Up Type: *Document Submission* Follow-Up Date: *11/02/2023*

Inspections / Reviews *(continued)*

11/02/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/01/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1 was admitted to the home on [REDACTED]-23 with diagnoses of Dementia with Behavioral Disturbance and Hallucinations. The resident's preadmission screening indicates that the resident has an extensive level of supervision needed. The home indicated on the preadmission screening that the resident's needs can be met by the home.

Immediately upon admission, Resident #1's behaviors began escalating:

- [REDACTED]-23- admitted to the secured unit, request to leave. Informed staff [REDACTED] would "push you down to the ground, if I have to break the doors down!"
- [REDACTED] 23 - aggressively lifting the walker off of the ground while yelling and swinging the walker at resident #2.
- [REDACTED]-23 became aggressive with staff. When redirected by staff, resident # 1 swung [REDACTED] hand aggressively towards staff.
- [REDACTED]-23- walked out in the hall, and stripped all clothing off. Resident #1 became aggressive and hit staff.
- [REDACTED]-23 at 4:27pm, resident #1 became aggressive, yelling in loud tones at other residents, redirection techniques not useful in assisting in reducing the aggression.

On [REDACTED]-23 at [REDACTED] pm, resident #1 forcefully pushed resident #3 to floor. Resident #3, was transported to the hospital for evaluation of a head injury, and was diagnosed with a hematoma.

Plan of Correction

Accept ([REDACTED] - 10/31/2023)

Resident #1 violated Resident #3's rights to be free from abuse and mistreatment. Immediate steps taken to protect Resident #3 included transporting Resident #3 to the hospital for evaluation. To protect other residents, Resident #1 was placed on Alert Charting with hourly monitoring checks for the rest of the night and through the next shift. Documentation indicates Resident #1 did not have further behaviors of concern during this period (Exhibit I).

Because this incident was unwitnessed by staff, and no other witness statements were documented, it cannot be determined if Resident #1 had a hallucination, misinterpreted Resident #3's presence, or whether other antecedents may have contributed to the incident.

Ongoing monitoring of Resident #1 indicated that Resident #1 may have sustained a change of condition and facility staff sought a geropsych/behavioral health unit transfer to evaluate Resident #1's status. Following Resident #1's transfer to a BHU, Resident #1 sustained an injury and was discharged from this Personal Care Home.

To prevent further incidents, the facility's General Manager (GM), Health and Wellness Director (HWD), and Opal Manager (OM) will conduct training for all staff by 10/31/23 regarding reporting aggressive/unusual behaviors as "Incidents" rather than as chart notes. Training of new employees will be conducted and documented as part of their respective onboarding process.

Incident Report notifications are sent immediately to the GM and HWD and require investigation/follow up by the GM and HWD within 24 hours, or sooner for sentinel events. Individual resident incidents may warrant a re-assessment, the implementation of interim support plans, including revised interventions, staff training, and

42b - Abuse (continued)

practitioner notifications requesting further evaluation.

Frequent resident incident reports serve to identify a significant change of condition, warranting a comprehensive review of the assessment, effectiveness of the interventions and support plan, and may require immediate actions to prevent other residents from abuse, such as 1:1 monitoring, until the situation has stabilized/been determined effective, or transfer/discharge is arranged.

In addition to reviewing each incident as they occur, the GM and HWD will include incident report trends in the facility's quarterly Quality Management review. Quality Management reviews will also include a review of staff training records and the implementation of the facility's Plans of Correction to ensure the facility is compliant with operating regulations.

Proposed Overall Completion Date: 10/31/2023

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

Implemented (████) 11/02/2023)

202 - Prohibitions**2. Requirements**

2600.

202. The following procedures are prohibited:

Description of Violation

On 7-18-23 at 10:00am, hospice made an attempt to assist resident #3 with care. Resident #3, demonstrated some concerns with receiving care. Staff person B, observed the hospice aide hold and pull the arm of resident #1, attempting to restrain █████ movements away from the caregiver.

Plan of Correction

Accept (████) - 10/31/2023)

The prohibited behavior related to the violation appears to be item (6) A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move his arms, legs, head or other body parts freely, is prohibited.

Facility records indicate that Resident #3 was not involved in the violation that occurred, rather it was Resident #4 who was receiving care and demonstrated concerns.

The support plan developed by the hospice agency and training of the hospice aide by the hospice agency did not meet the facility's regulatory requirements, resulting in this violation. The facility's GM has reported the incident to the hospice agency to ensure the agency enacts appropriate corrective actions to prevent this from happening again to any resident at this facility.

The GM will complete in-service training for all staff by 10/31/23, to ensure they make an immediate verbal report to the supervisor on duty and document observations of prohibited procedures by any care provider, including restraints, using the Incident Report process. The supervisor on duty is responsible for taking immediate action to determine whether abuse interventions and procedures are appropriate to protect the resident. The GM is responsible for ensuring the investigation and follow up are completed in accordance with facility policy and operational regulations.

202 - Prohibitions (continued)

The GM will utilize the facility's quarterly Quality Management process as described above in the 42b Plan of Correction to monitor compliance.

Proposed Overall Completion Date: 10/31/2023

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

Implemented (█ - 11/02/2023)

225c - Additional Assessment**3. Requirements**

2600.

225.c. The resident shall have additional assessments as follows:

2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's most recent assessment was completed on █-23. The support plan indicates that "[Resident] is noted with irritability and agitation at times. DCS to redirect as needed and approach with different approaches".

Between 6/20/23 and 8/1/23, Resident #1 engaged in behaviors that continued to escalate culminating in resident to resident physical contact on 8/1/23. However, the resident's support plan was not updated until 7/31/23.

Plan of Correction

Accept (█ - 10/31/2023)

The violation cannot be corrected for this occurrence. To prevent future incidents, the facility's GM, HWD, and OM will conduct training for all staff by 10/31/23 regarding reporting aggressive/unusual behaviors as "Incidents" rather than as chart notes. Training of new employees will be conducted and documented as part of their respective onboarding process.

Incident Report notifications are sent immediately to the GM and HWD and require investigation/follow up by the GM and HWD within 24 hours, or sooner for sentinel events. Individual resident incidents may warrant an immediate re-assessment to identify a change of condition and/or whether the previous assessment accurately reflects the resident's current needs, abilities and conditions. Frequent resident incident reports serve to identify a significant change of condition, warranting a comprehensive review of the assessment, and effectiveness of the interventions and support plan.

In addition to reviewing each incident as they occur, the GM and HWD will include incident report trends in the facility's quarterly Quality Management review. Quality Management reviews will also include a review of staff training records and the implementation of the facility's Plans of Correction to ensure the facility is compliant with operating regulations.

Proposed Overall Completion Date: 10/31/2023

225c - Additional Assessment (*continued*)

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

Implemented (█) - 11/02/2023)

234b - Support Plan Needs Elements

4. Requirements

2600.

234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated █-23, for resident #1 does not address the specific concerns with the aggressive behaviors of resident #1; from the following aspects:

- Intrusive behaviors towards other resident's, swinging the assistive devices other residents
- Unaccepting of staff assistance and redirections techniques not helpful in redirecting
- Aggressive with staff, resident #1 will hit staff and/or swing aggressively

Plan of Correction

Accept (█) - 10/31/2023)

Resident #1 has been discharged, so the support plan will not be updated to address the specific concerns identified in the violation.

The HWD and OM will conduct a review of all memory care residents' support plans to ensure they effectively identify the individual's needs. The review will be completed by 10/31/23.

The GM will ensure the Incident Report investigation/follow up process is in place (see POC for 42b above), which will facilitate a review of individual the resident's support plan. Support plans may initially be implemented on an interim basis as the situation is evaluated and the investigation is completed. Should the root cause of the incident be transitional (i.e., acute illness), the original support plan may be determined to be appropriate to meet the resident's needs. Should the cause be related to a change of condition, the support plan will be revised to identify the resident's new/current needs. The GM and HWD will monitor the implementation and effectiveness of the facility's compliance in accordance with the incident reporting and assessment processed identified in the POC for 42b and 225c above.

Proposed Overall Completion Date: 10/31/2023

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

Implemented (█) - 11/02/2023)