pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LANCASTER PCH LLC**
LEGAL ENTITY

To operate **LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER**
NAME OF FACILITY OR AGENCY

Located at **31 MILLERSVILLE ROAD, LANCASTER, PA 17603**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **100** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 22, 2023** until **June 22, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333061**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: DECEMBER 22, 2023

Lancaster PCH LLC
31 Millersville Road
Lancaster, Pennsylvania 17603

RE: Legend Personal Care and Memory Care of Lancaster
License #: 333060

Dear Lancaster PCH LLC:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on June 6-8, 2023, August 29-31, 2023 and September 27-28, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (333060) dated January 9, 2024 to January 9, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2);(4);(5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.16(c)	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.42(b)	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.52	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.63(a)	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.85(d)	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.185(a)	II	73	$5	$365	5 calendar days from mailing date of this letter
2600.190(a)	II	73	$5	$365	5 calendar days from mailing date of this
2600.227(g)	II	73	$5	$365	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *01/09/2024*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

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

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *06/08/2023*

Inspection Dates and Department Representative

06/06/2023 - On-Site: [redacted]
06/07/2023 - On-Site: [redacted]
06/08/2023 - On-Site: [redacted]
06/12/2023 - Off-Site: [redacted]
06/13/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *40* **Residents Served**: *31*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *39* **Have Physical Disability**: *0*

Inspections / Reviews

06/06/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/07/2023*

07/11/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/18/2023*

07/24/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *07/28/2023*

10/31/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home 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 personal care home.

Description of Violation

On 6/6/23, the home's current license, dated 1/9/23 through 1/9/24, was not posted in a conspicuous and public place in the home. The current licensing inspection summaries, from 5/3/22, 8/24/22, and 3/14/23, and a copy of the 2600 regulations were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 07/11/2023)***

Residence Director [redacted] replaced positing of License on 6/6/2023. photo attached. A sign Directing interested Parties to the current inspection summaries and 2600 regulations was posted on 6/9/2023, photo attached. Residence Director [redacted] to round monthly for 3 months to ensure it remains in place.

Licensee's Proposed Overall Completion Date: *09/09/2023*

Implemented - 10/31/2023)

16c - Written Incident Report

2. 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

On [redacted]/23, Resident 1 was found on the floor and sent to the hospital for evaluation. The resident was diagnosed with 6 fractured ribs. The home did not report this incident to the Department until [redacted]/23.

Repeated violation- 3/14/23, et. al.

Plan of Correction ***Accept - 07/11/2023)***

Reportable event training facilitated by Regional Director of operations, [redacted] and Regional Healthcare Director [redacted] on 6/12/2023 for with Residence Director [redacted], Healthcare Director [redacted] and Assistant healthcare Director [redacted]. Training for front line associates provided on 6/29/2023 by [redacted] Healthcare Director. [redacted] Residence Director to audit, incident reports weekly to ensure timely reporting.

Licensee's Proposed Overall Completion Date: *07/06/2023*

Not Implemented - 10/31/2023)

25a - Written Contract and Review

3. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident 2, admitted [redacted]/23, did not have a resident-home contract completed until [redacted]/23.

25a - Written Contract and Review *(continued)*

Plan of Correction ***Accept [redacted] - 07/10/2023)***

Audit of current resident files for compliance with 2600.25.a completed. by CSA [redacted] on 7/5/2023. Residence Director [redacted] to audit new resident files monthly for 3 months. to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *09/07/2023*

Implemented [redacted] - 10/31/2023)

25b - Contract Signatures

4. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] 23, for Resident 2 was not signed by the administrator or representative of the home.

The resident-home contract, dated [redacted] /23, for Resident 3 was not signed by the resident, administrator or representative of the home.

The resident-home contract, dated [redacted] /21, for Resident 4 was not signed by the resident, administrator or representative of the home.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

Audit of current resident files for compliance with 2600.25.a completed. by CSA [redacted] on 7/5/2023. Residence Director [redacted] to audit resident files monthly for 3 months. to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *09/30/2023*

Not Implemented ([redacted] - 10/31/2023)

52 - Hiring Staff

5. Requirements

2600.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

Staff person A was hired [redacted] 23, however, the staff person's criminal history background check was not completed until [redacted] /23.

Repeated violation - 5/3/22, et. al.

Plan of Correction ***Accept [redacted] - 07/10/2023)***

CSA [redacted] trained by Residence Director [redacted] on 6/9/2023 on 2600.52. Residence Director

52 - Hiring Staff (continued)

[redacted] *or Designee to audit compliance for all new hires. weekly for 8weeks.*

Licensee's Proposed Overall Completion Date: *08/14/2023*

Not Implemented [redacted] ***- 10/31/2023)***

63a - First Aid/CPR Training

6. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 6/2/23, 73 residents were present in the home. The second shift had only 1 staff person with current CPR and First Aid training and the third shift had none.

On 6/3/23, 73 residents were present in the home. The second shift had only 1 person with current CPR and First Aid training and the third shift had none.

On 6/4/23, 73 residents were present in the home. From 4:30 PM on, the second and third shifts had only 1 staff person with current CPR and First Aid training.

Repeated violation - 5/3/22, et. al.

Plan of Correction ***Accept*** [redacted] ***- 07/10/2023)***

CPR certification was provided on 6/29/2023 and 7/6/2023 please see attached, Home to offer additional training throughout the year for current staff and new hires to ensure continued compliance and Residence Director [redacted] *will audit schedule weekly for 8 weeks.*

Licensee's Proposed Overall Completion Date: *09/26/2023*

Not Implemented [redacted] ***- 10/31/2023)***

65b - Rights/Abuse 40 Hours

7. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Ancillary staff person B, hired [redacted] */20, did not complete training in emergency medical plan, mandatory abuse reporting, or reporting of reportable incidents and conditions within 40 hours of hire.*

Plan of Correction ***Accept*** [redacted] ***- 07/10/2023)***

All files Audited by CSA [redacted] *trained by Residence Director* [redacted] *on 6/9/2023 on 2600.65.b Residence Director* [redacted] *or Designee to audit compliance for all new hires. weekly for 8weeks.*

Licensee's Proposed Overall Completion Date: *08/24/2023*

65b - Rights/Abuse 40 Hours *(continued)*

Implemented [redacted] - 10/31/2023)

65g - Annual Training Content

8. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Ancillary staff person B did not receive training in resident rights during the 2022 training year.

Plan of Correction ***Accept[redacted] - 07/10/2023)***

In person training held for all associates on 6/29/2023 on resident rights and reportable incidents facilitated by Health Care Director[redacted] Residence Director [redacted] Monthly for 6 months to ensure continued Compliance.

Licensee's Proposed Overall Completion Date: *12/09/2023*

Implemented [redacted] - 10/31/2023)

82c - Locking Poisonous Materials

9. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A 28-ounce bottle of Purell Advanced Hand Sanitizer Naturals, with a manufacturer's label indicating to contact poison control right away if swallowed, was unlocked, unattended, and accessible in a kitchen cabinet in the secure dementia care unit (SDCU). None of the residents in the SDCU are assessed to be capable of recognizing and using poisons safely.

Plan of Correction ***Accept[redacted] - 07/10/2023)***

This violation was corrected on site by Residence Director [redacted] Environmental Checks to be completed by [redacted] or designee daily for 8 weeks to ensure no access to poisonous materials for residents in SDCU. All re-educated-on the importance of securing poisonous materials in SDCU at all times.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Not Implemented[redacted] - 10/31/2023)

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 6/6/23 at 9:45 AM there was a full, uncovered, unattended trash can in the bistro kitchenette.

Repeated violation - 8/24/22, 5/3/22, et. al.

85d - Trash Receptacles *(continued)*

Plan of Correction ***Accept [redacted] - 07/24/2023)***

Trash can was removed immediately by [redacted] Maintenance Director on 6//6/2023. This was corrected on 6/22/2023 when a new trash can with lid was put in place,see attached photo. environmental rounds [redacted] or designee. Environmental Checks to be completed by [redacted] or designee daily for 8 weeks to ensure all trash receptacles are covered.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Not Implemented [redacted] - 10/31/2023)

89b - Hot Water Temperature

11. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 6/6/23, the following hot water temperatures were observed:
- 9:45 AM, bistro kitchen sink, 125 degrees Fahrenheit
- 9:54 AM, laundry room sink near front hallway, 124 degrees Fahrenheit
- 9:58 AM, common area sink near bedroom A134, 129 degrees Fahrenheit
- 10:05 AM, activity sink in SDCU, 125 degrees Fahrenheit

Plan of Correction ***Accept [redacted] - 07/24/2023)***

This was corrected on 6/7/2023 by [redacted] Maintenance Director by adjusting the water mixing valve, turning down the overall temperature of the water to under 120 degrees farenheit. The Maintenance Director rounded faucets that day to ensure temperature was in compliance. [redacted] maintenance director or designee will round weekly for 8 weeks to ensure compliance.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented [redacted] - 10/31/2023)

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There is no thermometer in the freezer of the black GE refrigerator in the theater room.

Plan of Correction ***Accept [redacted] - 07/24/2023)***

This was corrected by Maintenance Director [redacted] on 6/12/2023 using a thermometer community had on hand, see attached photo.
[redacted] Maintenance Director or designee will round weekly for 8 weeks to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented [redacted] - 10/31/2023)

103i - Outdated Food

13. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

Inside the dry food storage of the kitchen, there was a dented 6 lbs 10 oz can of Sliced Peaches. This can of food was in rotation to be served.

Plan of Correction ***Accept [redacted] - 07/24/2023)***

This was corrected on site by [redacted] Sous Chef on 6/12. [redacted] removed the can and checked all others in stock for damage. [redacted] Chef or designee to round weekly for 8 weeks to ensure Compliance. Kitchen staff trained on checking cans on delivery before placing on shelf 6/16/2023, Please see attached.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented [redacted] - 10/31/2023)

109b - Rabies Vaccination

14. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 6/6/23, Resident 5's cat, Cash, was present at the home. The home does not have a current certificate of rabies vaccination for the cat.

Plan of Correction ***Accept [redacted] - 07/24/2023)***

On 6/12/2023 Residence Director [redacted] meet with residents POA and at that time asked that an appoint be made POA agreed and appointment for Cash is scheduled for 7/14/2023. All current resident files to be audited by CSA [redacted] for completion. of current rabies certificates, ongoing compliance to be maintained by Residence Director [redacted] or designee will round monthly for 3 months.

Licensee's Proposed Overall Completion Date: *09/12/2023*

Implemented [redacted] - 10/31/2023)

126a - Furnace Inspection

15. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The last inspection of the home's furnaces was conducted on 12/21/21.

Plan of Correction ***Accept [redacted] - 07/24/2023)***

"An HVAC inspection was immediately scheduled by the director of maintenance for 7/6/23. Awaiting copy of the visit summary to add to this report.
"Moving forward, the director of maintenance will set a tickler reminder in the outlook calendar (or other preventive maintenance system) for August 1 to ensure that a yearly inspection and cleaning occurs prior to the start of the heating season.

126a - Furnace Inspection (continued)

"The administrator will set an outtlook tickler for September 1 to check with the director of maintenance to ensure that the annual inspection and cleaning occurs prior to the start of the heating season.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented [redacted] - 10/31/2023)

126b - Furnace Cleaning

16. Requirements

2600.
126.b. Furnaces shall be cleaned according to the manufacturer's instructions. Documentation of the cleaning shall be kept.

Description of Violation

The home's furnaces were last cleaned on 12/21/21.

Plan of Correction ***Accept ([redacted] - 07/24/2023)***

HVAC cleaning preformed on 7/6/2023. will attach documentation once received. Home will follow Manufactures recommendation for yearly cleaning moving forward.

Licensee's Proposed Overall Completion Date: *07/24/2023*

Implemented [redacted] - 10/31/2023)

132a - Monthly Fire Drill

17. Requirements

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 months of December or July of 2022.

Plan of Correction ***Accept ([redacted] - 07/11/2023)***

Fire drill held 6/21/2023 at 5:50am, secondary drill held on 6/26/2023 at 6:30am. Continued Compliance shall be monitored monthly for 3 months by Residence Director [redacted] or designee. Maintenance Director re-educated on 2600.132.a by Residence Director [redacted] on 6/9/2023 please see attached.

Licensee's Proposed Overall Completion Date: *09/06/2023*

Implemented ([redacted] - 10/31/2023)

132e - Fire Drill Sleeping Hours

18. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home has not conducted a fire drill during sleeping hours for more than 12 months.

132e - Fire Drill Sleeping Hours *(continued)*

Plan of Correction ***Accept (- 07/11/2023)***

Fire drill held during sleeping hours on 6/21/2023 at 5:50am, secondary drill held on 6/26/2023 at 6:30am. Continued Compliance shall be monitored monthly for 3 months by Residence Director or designee.

Licensee's Proposed Overall Completion Date: *09/06/2023*

Implemented (- 10/31/2023)

132h - Designated Meeting Place

19. Requirements

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 9/30/22 at 9:45 AM, 2 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

During the fire drill on 8/30/22 at 9:45 AM, 2 residents did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Accept - 07/24/2023)***

Residence Director provided education to Maintenance Director on required information for fire drill compliance on 6/9/2023. Residence Director or designee shall monitor for compliance monthly for 3months.

Licensee's Proposed Overall Completion Date: *09/06/2023*

Implemented - 10/31/2023)

144b - Policy on Smoking

20. Requirements

2600.
144.b. The home rules shall specify whether the home is designated as smoking or nonsmoking.

Description of Violation

The home has a no smoking policy. On 6/6/23 at 1:45 PM, Resident 6 was interviewed about smoking in the enclosed courtyard. The resident admitted to smoking and a burn hole was observed on the red cushion where the resident was sitting. There was also a pile of ashes in front of a rocking chair where the resident admitted to smoking previously.

Plan of Correction ***Accept - 07/24/2023)***

The Maintenance director cleaned the ashes from the floor and ensured that no cushions with burn holes remained on 6/7 (Pictures attached). The community has established on 7/12 that it will continue to allow smoking outside of the building in a designated area which has now been defined below, and per the resident handbook, while smoking is not allowed in the building, there is a place on the grounds where residents may smoke. The community has purchased a smoker's pot (receipt attached) and will make this area available to residents who wish to smoke. This change was communicated to residents at their resident council meeting on 7/11 and the new policy distributed in writing on 7/14/2023 (attached)

144b - Policy on Smoking *(continued)*

Licensee's Proposed Overall Completion Date: *07/21/2023*

Implemented (- 10/31/2023)

171b5 - First Aid Kit

21. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the Buick LaCrosse used to transport residents does not include a breathing shield.

Plan of Correction ***Accept (- 07/11/2023)***

This was corrected by Health care Director on 6/12/2023. The community has secured all first aid kits with breakable ties, such that access and use of any item would be indicated by a broken tag. Health Care Director or designee will audit the first aid kits in the vehicles weekly for 8 weeks to ensure compliance with all required items.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Not Implemented - 10/31/2023)

184a - Resident's Meds Labeled

22. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident 2's Levalbuterol TAR HFA 45 MCG INH states to take every eight hours as needed, however, the original prescriber order and MAR state to take the medication every six hours as needed.

Plan of Correction ***Accept 07/24/2023)***

The Health Care Director confirmed on 6/8 the order and added a change in direction sticker to the inhaler. Health Care Director or designee to audit all new Move ins and 15 percent of existing Residents, weekly for 8 weeks to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Not Implemented - 10/31/2023)

185a - Implement Storage Procedures

23. Requirements

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

Resident 3's glucometer was not dated and timed correctly as readings stored in it were several days off from when

185a - Implement Storage Procedures (continued)

the readings were actually taken. In addition, a blood sugar reading of 194 was recorded on the resident's MAR for 6/6/23 at 8 AM, however this reading was not stored in the resident's glucometer. Readings stored in Resident 3's glucometer include:

6/7 at 8:41 186
5/23 at 1912 180
5/22 at 1921 169
5/21 at 1919 188
5/20 at 2127 163
5/19 at 1920 211

Several readings are stored in Resident 7's glucometer which were not recorded in the MAR including:

5/25 at 6:25am 37
5/22 at 8:43am 82
5/22 at 7:01am 35
5/22 at 7:00am 31

In addition, a reading of 53 was recorded on the Resident's MAR on 5/22 at 7:22 AM, however, was not stored in Resident 7's glucometer.

Repeated violation - 8/24/22, 5/3/22, et. al.

Plan of Correction ***Accept [redacted] - 07/11/2023)***

Health Care Director [redacted] and Assistant Health Care Director [redacted] will provide Med-Tech training and education surrounding 2600 185.a on 6/29/2023and will audit daily for 6weeks to ensure compliance in dates, time, calibrations and missed entry's, Health Care Director [redacted] or designee will audit monthly thereafter.

Licensee's Proposed Overall Completion Date: *07/24/2023*

Not Implemented ([redacted] - 10/31/2023)

187b - Date/Time of Medication Admin.

24. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 2's MAR does not include the initials of the staff person who administered the following medications and treatments on 6/1/23 at 8:00 PM:
- Alpha Lipoic Acid 600 MG, take 1 capsule in the evening
- Diclofenac Sodium 1% Gel, apply 1 gram topically to right great toe twice daily for pain
- Fluticasone-Salmeterol 250-50, inhale 1 puff twice daily
- T.E.D. Stockings, take off in the evening

Repeated violation - 5/3/22, et. al.

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Accept [redacted] - 07/11/2023)***

HealthCare Director [redacted] provided training to Med-techs on 6/29/2023 for 187.b. Starting 6/12/2023 Healthcare Director [redacted] or designee will audit the quick MAR variance report daily to monitor Med Tech admin sign off and address any discrepancies, including coaching and re-education on missing as well as reporting to DHS. Daily for 6 weeks

Licensee's Proposed Overall Completion Date: *07/24/2023*

Implemented [redacted] - 10/31/2023)

187d - Follow Prescriber's Orders

25. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed Alpha Lipoic Acid 600 MG Cap, take 1 capsule by mouth in the evening. This medication was administered on 4/27, 4/28, 4/29, 4/30, 5/1, and 5/2/23 at 8:00 AM.

Plan of Correction ***Accept ([redacted] - 07/11/2023)***

Beginning 6/12/2023 Healthcare Director or designee will reconcile meds for all new move ins day of move in. Healthcare Director or designee will audit medication for reconciliation with pharmacy audits weekly for 6 weeks.

Licensee's Proposed Overall Completion Date: *07/24/2023*

Not Implemented [redacted] - 10/31/2023)

190a - Completion Medication Course

26. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person C, who received initial medication training on [redacted]/22, has not completed additional training including medication administration record reviews or observations, and passed medications to residents on 6/1, 6/3, 6/4, and 6/6/23 at 8 AM.

Staff person D has not had annual medication training, including medication administration record reviews or observations since March 2021, and passed medications to residents on 5/2/23 at 8 AM and 6/3/23 at 8 AM, 5 PM, and 8 PM.

Staff person E has not had annual medication training, including medication administration record reviews or observations since April 2021, and passed medications to residents on 5/3, 5/4, 5/16, 5/18, 5/28, and 6/3/23 at 8 AM.

Staff person F has not had annual medication training, including medication administration record reviews or observations since February 2022, and passed medications to residents on 6/1, 6/2, and 6/6/23 at 8 AM and 8 PM.

Repeated violation - 5/3/22, et. al.

190a - Completion Medication Course *(continued)*

Plan of Correction ***Accept (- 07/24/2023)***

RD performed a file audit for all MT associates 6/6 and any staff without current medication training were removed from the schedule and not permitted to administer medication. Substitute, licensed personnel were scheduled for each shift to ensure that qualified staff administer medications. On 6/13/2023, Regional medication trainer performed medication training for staff without current training. On 6/13/2023 Healthcare Director completed DHS Train the Trainer program on 6/13/2023 (see attached). All medication technicians have current training as of 6/13/2023. Beginning 9/1/2023 and quarterly (every three months) thereafter, the healthcare director will conduct an audit of all medication technicians to ensure that training is current. These audits will be added to and reviewed during the home's quality management review.

Licensee's Proposed Overall Completion Date: *07/14/2023*

Not Implemented (- 10/31/2023)

224a - Preadmission Screen Form

27. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2 was admitted to the home on /23, however, the resident's preadmission screening form was completed on /23.

Repeated violation - 5/3/22, et. al.

Plan of Correction ***Accept (- 07/24/2023)***

Helth Care Director and Assistant Healthcare Director were educated by RD move in procedures 2600.224.a on 6/9/2023.
By 7/7/2023 Healthcare Director audited all current resident files to ensure that the pre-admission screening contained a determination that the home could meet the needs of the resident. Moving forward, Health Care Director, or designee will audit all new resident charts for pre-screen that contains a determination that the home can meet the needs of the resident.

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented (- 10/31/2023)

28. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident 2's preadmission screening form, dated /23, does not include a determination that the needs of the resident can be met by the services provided by the home.

224a - Preadmission Screen Form *(continued)*

Plan of Correction ***Accept (07/24/2023)***

By 7/7/2023 Healthcare Director audited all current resident files to ensure that the pre-admission screening contained a determination that the home could meet the needs of the resident. Moving forward, Health Care Director, or designee will audit all new resident charts for pre-screen that contains a determination that the home can meet the needs of the resident..

Licensee's Proposed Overall Completion Date: *08/24/2023*

Implemented - 10/31/2023)

225c - Additional Assessment

29. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident 8's current assessment was completed on /23. however, the resident's previous assessment was completed on 3/20/22.

Plan of Correction ***Accept (- 07/24/2023)***

On 7/11/2023 Healthcare Director completed an audit of all charts to ensure that assessments had been completed timely post move in and ensuring support plans were completed timely for pre-screen compliance with 224a. Healthcare Director or designee will audit all resident charts to ensure timely completion of assessments post move in to ensure support plans are completed timely for pre-screen compliance with 224a, weekly for 8 weeks.

Licensee's Proposed Overall Completion Date: *09/08/2023*

Not Implemented - 10/31/2023)

227a - Support Plan 30 Days

30. Requirements

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Violation

Resident 9 was admitted on /22; however, the resident's initial support plan was not completed until /22.

Plan of Correction ***Accept (- 07/11/2023)***

Helth Care Director and Assistant Healthcare Director were educated by RD on SDCU support Plan procedures on 6/9/2023.
Healthcare Director or designee will audit all resident charts for support plan compliance with 227a weekly for 8 weeks.

Licensee's Proposed Overall Completion Date: *08/28/2023*

Implemented 10/31/2023)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *01/09/2024*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

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

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *103* **Waking Staff**: *77*

Inspection Information

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

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *08/31/2023*

Inspection Dates and Department Representative

08/28/2023 - Off-Site: [redacted]
08/29/2023 - On-Site: [redacted]
08/30/2023 - On-Site: [redacted]
08/31/2023 - On-Site: [redacted]
09/05/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *72*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *40* **Residents Served**: *27*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *72*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *31* **Have Physical Disability**: *1*

Inspections / Reviews

08/28/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/25/2023*

10/04/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/19/2023*

12/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *12/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

12/14/2023 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *12/14/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.

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

On or about 6/22/2023, the home was made aware of a complaint of verbal abuse. The allegation was reported to Staff Person A, however, was not reported to the Department or the local area agency on aging.

Repeated Violation - 3/14/2023, et al.

Plan of Correction ***Accept (10/20/2023)***

Residence Director [redacted] called AAA on 9/4/2023 to report incident and was told resident was no longer in our care and there was no need to report. Act 13 event training facilitated by Regional Director of operations, [redacted] and Regional Healthcare Director [redacted] on 9/20/2023 for with Residence Director [redacted] Healthcare Director [redacted] and Assistant healthcare Director [redacted] Training for front line associates provided will be provided 9/28/2023 by [redacted] Healthcare Director. [redacted] Residence Director to audit, incident reports weekly for 8 weeks beginning 10/16 to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/04/2023*

Implemented (12/5/2023)

16c - Written Incident Report

2. 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

On or about 6/22/2023, the home was made aware of a complaint of verbal abuse. The allegation was reported to Staff Person A, however, was not reported to the Department or the local area agency on aging.

Resident 1 is prescribed Humalog insulin, 15 units to be administered 3 times a day before meals. The resident did not receive this medication from 8/4/2023 at 11:00 AM through 8/5/2023 at 5:00 PM because it was not available. This medication error was not reported to the Department until 8/30/2023.

Resident 1 is prescribed Prosource Plus Protein Liquid 30 ML by mouth once daily. The resident did not receive this medication from 8/14/2023 through 8/17/2023 because it was not available. This medication error was not reported to the Department until 8/20/2023.

Resident 2 is prescribed Memantine HCL 10 MG, 1 tablet by mouth twice daily. The resident did not receive this medication on 8/4/2023 at 5:00 PM or on 8/5/2023 at 5:00 PM because it was not available. This medication error has not been reported to the Department.

Repeated Violation - 3/14/2023, et al.

16c - Written Incident Report *(continued)*

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Residence Director [redacted] called AAA on 9/4/2023 to report incident and was told resident was no longer in our care and there was no need to complete act 13. Reportable event for resident 1 from 8/4 and 8/5 filed late on 10/16/2023 by Residence Director [redacted] Reportable event training facilitated by Regional Director of operations, [redacted] and Regional Healthcare Director [redacted] on 9/20/2023 for with Residence Director [redacted], Healthcare Director [redacted] and Assistant healthcare Director [redacted]. Training for front line medication associates was held on 9/20/2023 by [redacted] Healthcare Director. Health Care Director [redacted] or designee to audit missed med report daily, for 60 days beginning 10/9/2023 to ensure compliance and report any medication error to BHSL within 24 hours.

Licensee's Proposed Overall Completion Date: *12/09/2023*

Not Implemented ([redacted] - 12/5/2023)

16d - Final Incident Report

3. Requirements

2600.
16.d. The home shall submit a final report, on a form prescribed by the Department, to the Department's personal care home regional office immediately following the conclusion of the investigation.

Description of Violation

On 7/17/2023, the home submitted initial incident reports regarding allegations of abuse of Residents 3 and 4. The home did not submit final reports to the Department.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Report of final disposition of incident for residents 3 and 4 filed by residence director [redacted] on 10-16-2023. Reportable event training facilitated by Regional Director of operations, [redacted] and Regional Healthcare Director [redacted] on 9/20/2023 for with Residence Director [redacted], Healthcare Director [redacted] and Assistant healthcare Director [redacted]. Training for front line associates will be provided on 9/28/2023 by [redacted] Healthcare Director. [redacted] Residence Director to audit, incident reports weekly for 8 weeks beginning 10/9/23 to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/04/2023*

Implemented [redacted] - 12/5/2023)

25b - Contract Signatures

4. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contracts for Residents 1, 3, 5, and 6 were not signed by the administrator or a designee.

25b - Contract Signatures *(continued)*

Plan of Correction ***Accept (- 10/20/2023)***

Audit of current resident files for compliance with 2600.25.a completed. by CSA on 8/30/2023. Contracts for residents 1,3,5 and 6 on 8/30/2023 by Residence Director . Residence Director to audit resident files monthly for 3 months beginning 9/30/2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Not Implemented - 12/5/2023

42c - Treatment of Residents

5. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On the evening of 7/16/2023, Staff Person B was observed grabbing Resident 3's hands and twisting the resident, forcing the resident to dance. The resident repeatedly asked staff to stop and leave alone. Staff Person B was also observed sitting in a wheelchair and running it into Resident 4, forcing the resident to back up into a chair. The resident was heard asking the staff to stop and leave alone.

Plan of Correction ***Accept - 10/20/2023)***

Staff member B was terminated on /2023. Resident rights training with a focus on dignity and respect for front line associates will be provided on 9/28/2023 by Healthcare Director. Residence Director. Residence Director to provide ongoing training to new staff and audit for monthly for 3 months beginning on 9/10/2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *11/10/2023*

Implemented (- 12/5/2023

52 - Hiring Staff

6. Requirements

2600.
52. Staff Hiring, Retention and Utilization - Hiring, retention and utilization of staff persons shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults) and other applicable regulations.

Description of Violation

Staff Person B was hired /2023, however, no criminal background check was performed until /2023.

Repeated Violation - 5/3/2022, et al.

Plan of Correction ***Accept - 10/20/2023)***

CSA completed a background check for staff member B on 8/29/2023. CSA re- trained by Residence Director on 9/20/2023 on 2600.52. Residence Director. A complete audit of teammate files was completed by RD and CSA on 9/20/2023. no other staff members background checks were found to be out of compliance.

52 - Hiring Staff (continued)

[redacted] *or Designee to audit compliance for all new hires. weekly for 8 weeks beginning 9/30/2023.*

Licensee's Proposed Overall Completion Date: *11/15/2023*

Not Implemented ([redacted] - 12/5/2023)

63a - First Aid/CPR Training

7. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 8/13/2023 from 10:00 PM to 6:00 AM, there were 74 residents in the home and 4 staff working, none of whom had current first aid certification.

On 8/14/2023 from 10:00 PM to 6:00 AM, there were 74 residents in the home and 4 staff working. Only 1 staff had CPR certification and none had current first aid certification.

On 8/15/2023 from 10:00 PM to 6:00 AM, there were 74 residents in the home and 5 staff working, none of whom had current first aid certification.

Repeated Violation - 5/3/2022, et al.

Plan of Correction ***Accept ([redacted] - 10/04/2023)***

CPR/First aid certification will be offered on provided on 10/4/2023 and 10/5/2023. Home to offer additional training.
throughout the year for current staff and new hires to ensure continued compliance and Residence Director [redacted] will audit schedule weekly for 8 weeks.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Not Implemented [redacted] - 12/5/2023)

82c - Locking Poisonous Materials

8. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A bottle of "Bye Bye Germs Antibacterial Hand Wash" with a manufacturer's label that states, "if swallowed get medical help or contact a poison control center right away" was unlocked, unattended, and accessible in the cabinet above the activities room sink in the secure dementia care unit (SDCU). The residents in the SDCU have not been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept (- 10/20/2023)***

This violation was corrected on site by Residence Director [redacted] Environmental Checks to be completed by [redacted] or designee daily for 8 weeks to ensure no access to poisonous materials for residents in SDCU beginning 9/30/2023. All staff reeducated the importance of securing poisonous materials in SDCU at all times By Residence Director [redacted] on 8/31, 9/4 and 9/5.

Licensee's Proposed Overall Completion Date: *11/11/2023*

Not Implemented (12/5/2023)

85a - Sanitary Conditions

9. Requirements

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

Description of Violation

On 8/31/2023 at approximately 10:15 AM, feces was smeared on the carpeted hallway floor of the SDCU and spanned approximately 15 feet. According to staff interviews, an accident occurred the previous shift.

Plan of Correction ***Accept (- 10/20/2023)***

This violation was corrected immediately on 8/31/2023 by Maintenance Director [redacted] who shampooed the carpet. Environmental Checks to be completed daily by [redacted] or designee for 8 weeks beginning 9/1/2023 to ensure compliance.

Licensee's Proposed Overall Completion Date: *10/27/2023*

Implemented (- 12/5/2023)

85d - Trash Receptacles

10. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 8/29/2023 at 9:50 AM, there was a full, uncovered, unattended trash can next to the coffee machine in the kitchen. The same can was observed full, uncovered, and unattended on 8/20/2023 at 4:50 PM.

Repeated Violation - 8/24/2022, 5/3/2022, et al.

Plan of Correction ***Accept - 10/20/2023)***

This was corrected immediately on 8/29/203 by Chef [redacted] Kitchen staff educated on 8/31/2023 by Chef [redacted] on keeping covers on trash cans when not actively in use. Environmental Checks to be completed by or designee daily for 8 weeks beginning on 8/31/23 to ensure all trash receptacles are covered and continued compliance.

Licensee's Proposed Overall Completion Date: *10/26/2023*

Not Implemented (- 12/5/2023)

101i - Access to Bedroom

11. Requirements

2600.
101.i. A resident shall have access to his bedroom at all times.

Description of Violation

Multiple staff stated that bedroom doors in the SDCU are routinely locked to prevent residents from entering. Multiple bedrooms were checked and were observed to be locked including: A317, A325, A323, A310, A305, A304, A302, and A301.

Plan of Correction ***Accept [redacted] - 10/04/2023)***

Home will provide training to all staff on 2600.101.i on 9/28/2023. [redacted] Assistant Healthcare Director will round daily to ensure residents have access to their apartments. Assistant Healthcare Director [redacted] or designee will complete audit weekly over 8 weeks to ensure compliance.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Implemented ([redacted] - 12/5/2023)

141a 1-10 Medical Evaluation Information

12. Requirements

2600.
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:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident 4's medical evaluation, dated [redacted]/2023, does not include the immunization history, ability to self-administer medications, health status, cognitive functioning or the medical professional's license number.

Plan of Correction ***Accept ([redacted] - 10/20/2023)***

DME for resident 4 was completed by PCP on 8/31/2023 to reflect immunization history, ability to administer medications, heal status, cognitive function and medical professional's license number. Medical Evaluation Training facilitated by Regional Director of operations, [redacted] and Regional Healthcare Director [redacted] on 9/20/2023 for with Residence Director [redacted] Healthcare Director [redacted] and Assistant healthcare Director [redacted] Training for front line associates will be provided on 9/28/2023 by [redacted] Healthcare Director. [redacted] Residence Director to audit, Med eval's weekly over 8 weeks beginning 9/28/2023 to ensure compliance.

Licensee's Proposed Overall Completion Date: *10/15/2023*

Implemented ([redacted] - 12/5/2023)

141a 1-10 Medical Evaluation Information *(continued)*

171b5 - First Aid Kit

13. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the Buick LaCrosse used to transport residents does not include a breathing shield.

Plan of Correction ***Accept (- 10/04/2023)***

This was corrected by Residence Director [redacted] on site. The community has secured all first aid kits with breakable ties, such that access and use of any item would be indicated by a broken tag. Health Care Director [redacted] or designee will audit the first aid kits in the vehicles weekly for 8 weeks to ensure compliance with all required items.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Not Implemented - 12/5/2023)

184a - Resident's Meds Labeled

14. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

The pharmacy label for Resident 7's Quetiapine Fumarate states to take 1 tablet by mouth after lunch and dinner but the order states to take 1 tablet at 1:00 PM.

Plan of Correction ***Accept - 10/20/2023)***

Assistant health care Director [redacted] checked against provider's order on 8/31/2023 and applied a change in order sticker on the bottle to ensure that the label matched the original prescriber Health Care Director [redacted] or designee to audit all new Move ins and 15 percent of existing Residents, weekly for 8 weeks beginning 10/13/2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *12/15/2023*

Not Implemented (12/5/2023)

185a - Implement Storage Procedures

15. Requirements

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

Resident 1's glucometer was reset on 8/30 and multiple readings stored in the meter were dated in February. In addition, the reading stored on 2/22 at 4:25 PM was 419 and the home's medication administration record (MAR) stated it was 421.

185a - Implement Storage Procedures (continued)

Readings stored in the glucometer included:

8/30 11:23 AM 486
2/23 7:25 AM 343
2/22 4:25 PM 419 (MAR states 421)
2/22 11:23 AM 511
2/22 8:07 AM 382
2/21 5:09 PM 503
2/21 10:51 AM 440
2/21 6:32 AM 383
2/20 4:51 PM 433
2/20 11:36 AM 502

Repeated Violation - 8/24/2022, 5/3/2022, et al.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Assistant Health Care Director [redacted] immediately corrected the glucometer on 8/30/2023. Health Care Director [redacted] and Assistant Health Care Director [redacted] provided Med-Tech training and education surrounding 2600 185.a on 9/ 20/2023. The Home only has the 1 meter belonging to resident 1. Health Care Director [redacted] audit daily for 6weeks beginning 9/4/2023 to ensure compliance in dates, time, calibrations and missed entries.

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

Not Implemented [redacted] 12/5/2023)

187d - Follow Prescriber's Orders

16. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 is prescribed Humalog insulin, 15 units three times a day before meals, however, it was not administered from 8/3/2023 at 11:00 AM to 8/5/2023 at 5:00 PM because it was not available in the home.

Resident 1 is prescribed Prosource Plus Protein Liquid, 30 ML by mouth once daily, however, it was not administered from 8/14/2023 through 8/17/2023 because it was not available in the home.

Resident 2 is prescribed Memantine HCL 10 MG Tablet, 1 tablet by mouth twice daily, however, it was not administered on 8/4/2023 and 8/5/2023 at 5:00 PM because it was not available in the home.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (JM - 10/04/2023)***

Beginning 9/20/2023 Healthcare Director [redacted] *and or Assistant Healthcare Director* [redacted] *will reconcile meds for all new move ins day of move in and will assign a designee to perform an additional check at this time.*

Healthcare Director or designee will audit medication for reconciliation with pharmacy audits weekly for 6 weeks.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Not Implemented [redacted] ***- 12/5/2023)***

190a - Completion Medication Course

17. Requirements

2600.

190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person C, who has not successfully completed the Department-approved medication administration course, administered medications to Resident 1 on: 8/7/2023 at 8:00 AM, 8/15/2023 at 8:00 AM, 8/18/2023 at 8:00 AM, 8/21/2023 at 8:00 AM, and 8/22/23 at 8:00 AM.

Staff Person D, who has not successfully completed the Department-approved medication course, administered medications to Resident 1 on: 8/5/2023 at 5:00 PM, 8/14/2023 at 5:00 PM, and 8/19/2023 at 5:00 PM.

Repeated Violation - 5/3/2022

Plan of Correction ***Accept*** [redacted] ***- 10/20/2023)***

Staff members C and D were immediately removed from med cart until training could be performed. Train the Trainer [redacted] *performed medication training for staff member C listed above on 9/5/2023 and Staff member D on 9/15/2023 Healthcare Director* [redacted] *audit trainings biweekly for 6months then throughout the year and monitor compliance with all Medication technicians.*

Licensee's Proposed Overall Completion Date: *10/15/2023*

Not Implemented ([redacted] ***- 12/5/2023)***

190b - Insulin Injections

18. Requirements

2600.

190.b. A staff person is permitted to administer insulin injections following successful completion of a Department-approved medications administration course that includes the passing of a written performance-based competency test within the past 2 years, as well as successful completion of a Department-approved diabetes patient education program within the past 12 months.

190b - Insulin Injections *(continued)*

Description of Violation

Staff Person E, who has not completed diabetic training, took blood sugars for Resident 1 on: 8/2/2023 at 4:00 PM, 8/6/2023 at 4:00 PM, 8/20/2023 at 4:00 PM, 8/25/2023 at 4:00 PM, and 8/29/2023 at 4:00 PM. Staff Person E also administered insulin to Resident 1 on 8/2/2023 at 4:00 PM and 8/6/2023 at 4:00 PM.

Staff Person F, who has not completed diabetic training, took blood sugars for Resident 1 on 8/3/2023 at 4:00 PM and 8/8/2023 at 4:00 PM.

Repeated Violation - 5/3/2022, et al.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Staff members E and F were immediately removed from administering diabetes medications and glucose checks until Diabetic training was completed for both. Diabetic training was provided for the above staff members on 8/5/2023.[redacted] [redacted] audit trainings biweekly for 6months then throughout the year and monitor compliance with all Medication technicians.

Licensee's Proposed Overall Completion Date: *01/30/2024*

Implemented [redacted] - 12/5/2023)

227d - Support Plan Medical/Dental

19. Requirements

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 4's support plan, signed 6/14/2023, does not include the behavior of wandering into other resident rooms or taking their belongings. Additionally, the support plan does not include if the resident can or cannot self-administer medications and does not include physical diagnoses, dental needs, dietary needs, or psychological diagnosis. Further, the support plan states that the resident requires no supervision or assistance in the event of an emergency, however, the previous support plan includes extensive supervision needs and immobility with assistance needed to evacuate. Resident 4 has a diagnosis of dementia and anxiety and resides in the SDCU.

Repeated Violation - 5/3/2022, et al.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Assistant Healthcare Director [redacted] re-assed resident 4 on.... Helth Care Director [redacted] and Assistant Healthcare Director [redacted] were educated by RD [redacted] [redacted] on SDCU support Plan procedures on 9/2/2023.
Healthcare Director [redacted] or designee will audit all resident charts for support plan compliance with 227a weekly for 8 weeks.

227d - Support Plan Medical/Dental (continued)

Licensee's Proposed Overall Completion Date: *9/2/2023*

Implemented (- 12/5/2023)

227g -Support Plan Signatures

20. Requirements

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 for Resident 7, completed 6/7/2023, was not signed by the assessor.

Repeated Violation - 5/3/2022, et al.

Plan of Correction ***Accept - 10/20/2023)***

Assistant Healthcare Director singed support plan on ------Helth Care Director and Assistant Healthcare Director were educated by RD on SDCU support Plan procedures on 9/20/2023.
Healthcare Director or designee will audit all resident charts for support plan compliance with 227a weekly for 8 weeks.

Licensee's Proposed Overall Completion Date: *9/20/2023*

Not Implemented (- 12/5/2023)

233c - Key-Locking Devices

21. Requirements

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

The code required to exit the SDCU was posted at the door by room A308, however, it was not current and did not disengage the lock.

Plan of Correction ***Accept - 10/04/2023)***

Code to SDCU near exit was updated at time of inspection by Maintenance Director. Maintenance Director will audit signs weekly for 6 weeks to ensure compliance and add additional checks when needed should the code change.

Licensee's Proposed Overall Completion Date: *10/13/2023*

Implemented - 12/5/2023)

254a - Records Discharge/Active

22. Requirements

254a - Records Discharge/Active *(continued)*

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 8/29/2023 at 9:05 AM, the controlled substance book was unlocked, unattended, and accessible on the medication cart located outside the private dining room. On 8/31/2023, from 9:50 AM to 9:58 AM, the controlled substance book was unlocked, unattended, and accessible atop the medication cart in the SDCU. The controlled substance books contain resident names, prescription and diagnosis information including for Residents 8 and 9 (SDCU).

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Controlled Substance book was secured inside locked med cart by staff by medication tech [redacted] on 8/29/2023 and by LPN [redacted] on 8/31/2023. Health Care Director [redacted] and Assistant Health Care Director [redacted] provided Med-Tech training and education surrounding 2600. 254.a on 9/20/2023. HCD and AHCD will monitor and audit daily for 6weeks to ensure compliance.

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

Not Implemented [redacted] - 12/5/2023)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *01/09/2024*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

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

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *104* **Waking Staff**: *78*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *09/28/2023*

Inspection Dates and Department Representative

09/25/2023 - Off-Site: [redacted]
09/27/2023 - On-Site: [redacted]
09/28/2023 - On-Site: [redacted]
10/04/2023 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *73*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *40* **Residents Served**: *27*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *73*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *31* **Have Physical Disability**: *1*

Inspections / Reviews

09/25/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/16/2023*

11/20/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/29/2023*

12/07/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *11/30/2023*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

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

On 7/17/2023 at 10:00 PM, an incident of abuse occurred between two residents. During this incident, Resident 1 struck Resident 2 with a shoe multiple times. Resident 2 then kicked Resident 1 in the stomach causing [redacted] to fall backwards and strike[redacted] head. Resident 1 was sent to the hospital for evaluation. This incident was not reported to the Department.

Repeated Violation - 3/14/2023, et al.

Plan of Correction ***Accept [redacted] 10/20/2023)***

Report was made for this incident to AAA but report to BHSL could not be provided to surveyor at time of survey. [redacted] Residence Director reported this incident to DHS on 10/17/2023. [redacted] Residence Director re-educated Assistant healthcare Director [redacted] on abuse reporting on 9/29/2023. RD [redacted] will audit reportable incidents daily for 4 weeks beginning on 9/30/2023.

Licensee's Proposed Overall Completion Date: *10/28/2023*

Not Implemented [redacted] 12/06/2023)

42b - Abuse

2. 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

On 7/17/2023 at 10:00 PM an incident of abuse occurred between two residents. During this incident, Resident 1 struck Resident 2 with a shoe multiple times. Resident 2 then kicked Resident 1 in the stomach causing [redacted] to fall backwards and strike [redacted] head.

On 9/18/2023 at 6:47 PM, Resident 2 was leaving Resident 3's bedroom. Resident 3 stated to "get out of here." Resident 2 began to argue with Resident 3 and Resident 2 swung [redacted] cane at Resident 3. Resident 2 then grabbed at Resident 3's arm scratching it.

On 9/19/2023 at 3:00 PM, Resident 2 struck Resident 3 on the face with a closed hand.

On 9/23/2023 at 10:45 PM, Resident 1 and 2 were arguing. Resident 2 bit Resident 1's hand and punched [redacted] in the face two times.

Repeated Violation - 3/14/2023, et al.

42b - Abuse *(continued)*

Plan of Correction ***Accept [redacted] - 10/20/2023)***

All instances of abuse listed above involved Resident 2, on [redacted]/2023 medication changes were made for resident by PCP, on 9/18/2023 PCP was notified, and family was asked to provide Private duty aid for one-on-one care from the hours of 8am-8pm, 9/19/2023 Family was asked to provide one on one care during all waking hours. Resident Director [redacted] will provide training to staff on resident abuse and behavioral de-escalation strategies on 10/26/2023. [redacted] Residence Director and assigned Department Mangers to round twice daily in the memory care beginning 9/25/2023 for 8 weeks to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *11/13/2023*

Not Implemented [redacted] - 12/05/2023)

183b - Meds and Syringes Locked

3. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 9/26/2023 at 9:05 AM, the medication cart for rooms 101 - 123 was unlocked, unattended, and accessible in the hallway next to the private dining room.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

This cart was found to need new batteries for locking mechanism. [redacted] Maintenance Director replaced batteries on 9/26/2023 and locked the cart. [redacted] Health Care Director provided education to medication technicians on battery replacement and how it effects the ability to safely lock cart on 9/28/2023. Healthcare Director [redacted] or designee will complete random cart checks for 8 weeks daily to ensure continued compliance beginning 9/27/2023.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 12/05/2023)

187c - Refusal of Medication

4. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Multiple medication refusals for Resident 5 are documented in the medication administration record (MAR), however, the home did not notify the prescriber of these refusals including:

9/4/2023 at 10:00 AM	*Mag 64 Tablet SA*
9/4/2023 at 10:00 AM	*Omeprazole DR 40 MG capsule*
9/4/2023 at 10:00 AM	*One Daily Womens Multivitamin*
9/4/2023 at 10:00 AM	*Sertraline HCL 100 MG tablet*
9/5/2023 at 10:00 AM	*MAG 64 Tablet SA*

187c - Refusal of Medication (continued)

9/5/2023 at 10:00 AM	*Omeprazole DR 40 MG capsule*
9/5/2023 at 10:00 AM	*One Daily Womens Multivitamin*
9/5/2023 at 10:00 AM	*Sertraline HCL 100 MG tablet*
9/7/2023 at 10:00 AM	*MAG 64 Tablet SA*
9/7/2023 at 10:00 AM	*Omeprazole DR 40 MG capsule*
9/7/2023 at 10:00 AM	*One Daily Womens Multivitamin*
9/7/2023 at 10:00 AM	*Sertraline HCL 100 MG tablet*
9/8/2023 at 8:00 PM	*Divalproex SOD ER 500 MG tablet*

Repeated Violation - 8/24/2022, 5/3/2022, et al.

Plan of Correction ***Accept [redacted] - 10/20/2023)***

PCP made aware of refusals listed above by Healthcare Director [redacted] on 9/28/2023. Medication Technicians educated on refusal procedures on 9/20/2023 by Healthcare Director [redacted]. Healthcare Director [redacted] or designee will audit med refusals daily to ensure procurers are being followed for 8 weeks beginning on 9/28/2023.

Licensee's Proposed Overall Completion Date: *11/23/2023*

Implemented ([redacted] - 12/05/2023)

187d - Follow Prescriber's Orders

5. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 4 is prescribed blood sugar checks three times a day. Blood sugar checks were not performed at 4:00 PM on 9/11, 9/12, 9/15, and 9/17/2023.

Resident 4 is prescribed Novolog Insulin, 10 units 3 times a day with meals. Novolog was not administered at 4:00 PM on 9/11, 9/12, 9/15, and 9/17/2023.

Plan of Correction ***Accept ([redacted] - 10/20/2023)***

This was immediately reported to PCP and DHS by [redacted] Health Care Director, Education provided to Medication Technicians on 9/20/2023 on following prescriber directions. [redacted] Health Care Director, or designee will audit missed medications daily to ensure procurers are being followed for 8 weeks beginning on 9/28/2023.

Licensee's Proposed Overall Completion Date: *11/23/2023*

187d - Follow Prescriber's Orders *(continued)*

Not Implemented (AS - 12/06/2023)

188b - Medication Error Reporting

6. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident 4 is prescribed blood sugar checks three times a day. Blood sugar checks were not performed at 4:00 PM on 9/11, 9/12, 9/15, and 9/17/2023. Resident 4 is prescribed Novolog Insulin, 10 units 3 times a day with meals. Novolog was not administered at 4:00 PM on 9/11 and 9/12/2023. These medication errors were not reported to the prescriber.

Plan of Correction ***Accept (- 10/20/2023)***

PCP made aware of missed meds listed above by Healthcare Director [redacted] on 9/28/2023. Medication Technicians educated on missed medication reporting procedures on 9/20/2023 by Healthcare Director [redacted] Healthcare Director [redacted] or designee will audit missed meds daily to ensure procedures are being followed for 8 weeks beginning on 9/28/2023.

Licensee's Proposed Overall Completion Date: *11/23/2023*

Not Implemented (12/05/2023)

225c - Additional Assessment

7. 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 assessment, dated /2023, does not include aggressive behaviors noted to have occurred on 7/17/2023 when the resident was hitting another resident with a shoe.

Plan of Correction ***Accept - 10/20/2023)***

Resident 1's assessment was updated by Assistant Health Care Director [redacted] to include behaviors on 9/28/2023. [redacted], Residence Director re-educated Assistant healthcare Director [redacted] on significant changes and assessment addendums on 9/29/2023. RD [redacted] or designee will audit significant change assessments and addendums weekly for 8 weeks beginning on 9/30/2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *11/20/2023*

Not Implemented (- 12/05/2023)

227g -Support Plan Signatures

8. Requirements

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

Description of Violation

Resident 2's assessment and support plan, signed by the resident on [redacted]/2023, was not signed by the assessor.

Repeated Violation - 5/3/2022

Plan of Correction ***Accept [redacted] - 10/20/2023)***

Resident 2's support plan was signed by assessor Assistant Health Care Director [redacted] on 9/28/2023. [redacted] Residence Director re-educated Assistant Health Care Director [redacted] on 2600.277.g on 9/29/2023. and at this time completed a full Aduit of support plans and found them to be in signed and in compliance. RD [redacted] or designee will audit support plans weekly for 8 weeks beginning on 9/30/2023 to ensure continued compliance.

Licensee's Proposed Overall Completion Date: *11/20/2023*

Not Implemented [redacted] - 12/05/2023)

254a - Records Discharge/Active

9. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 9/27/2023, the controlled substance log, including resident names, medical diagnosis information, and prescribed medications, was unlocked, unattended, and accessible atop the medication cart in the hallway next to the dining room.

Plan of Correction ***Accept [redacted] 10/20/2023)***

Controlled Substance book was secured inside locked med cart by medication tech [redacted] on 8/31/2023 and was provided with immediate re-education from Health Care Director [redacted]. Health Care Director [redacted] and Assistant Health Care Director [redacted] provided Med-Tech training and re-education surrounding 2600. 254.a on 9/28/2023 to all Medication Technician's. HCD and AHCD will monitor and audit daily for 6weeks to ensure compliance.

Licensee's Proposed Overall Completion Date:

Not Implemented ([redacted] 12/06/2023)