

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

December 26, 2023

[REDACTED], EXECUTIVE DIRECTOR  
PARAMOUNT SENIOR LIVING AT MAYTOWN LLC  
2760 MAYTOWN ROAD  
MAYTOWN, PA, 17550

RE: PARAMOUNT SENIOR LIVING AT  
LANCASTER COUNTY  
2760 MAYTOWN ROAD  
MAYTOWN, PA, 17550  
LICENSE/COC#: 33390

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/11/2023 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: *PARAMOUNT SENIOR LIVING AT LANCASTER COUNTY* License #: 33390 License Expiration: 08/15/2024  
 Address: 2760 MAYTOWN ROAD, MAYTOWN, PA 17550  
 County: LANCASTER Region: CENTRAL

**Administrator**

Name: [REDACTED] Phone: [REDACTED]

**Legal Entity**

Name: *PARAMOUNT SENIOR LIVING AT MAYTOWN LLC*  
 Address: 2760 MAYTOWN ROAD, MAYTOWN, PA, 17550  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: *C-2 LP* Date: 11/17/1999 Issued By: *L & I*

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 111 Waking Staff: 83

**Inspection Information**

Type: *Partial* Notice: *Unannounced* BHA Docket #: 0  
 Reason: *Incident* Exit Conference Date: 12/11/2023

**Inspection Dates and Department Representative**

12/11/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 116 Residents Served: 78

**Secured Dementia Care Unit**  
 In Home: Yes Area: SDU Capacity: 44 Residents Served: 31

**Hospice**  
 Current Residents: 8

**Number of Residents Who:**  
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 78  
 Diagnosed with Mental Illness: 29 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 33 Have Physical Disability: 0

**Inspections / Reviews**

12/11/2023 Partial  
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: 12/24/2023

12/21/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 12/22/2023  
 Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: 12/28/2023

Inspections / Reviews *(continued)*

12/26/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/22/2023

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**

On [REDACTED] at approximately [REDACTED], Staff Member B heard yelling coming from Resident 1's room. Upon investigation, Staff Member B witnessed Staff Member A grabbing Resident 1's forearm while pushing him/her into the wheelchair. Resident 1 also reported to Staff Member B that Staff member A was pinching him/her. Resident 1 sustained bruising on both arms as a result of the incident.

*Repeated Violation-11/15/23, 3/14/23, et al and 12/6/22, et al*

**Plan of Correction**

Accept [REDACTED] - 12/21/2023)

Staff member B was hired on [REDACTED] as a Resident Assistant. Staff member B was trained on Resident Rights, Detecting and Reporting Abuse and Neglect, and reporting incidents on [REDACTED]. [REDACTED] was trained on [REDACTED] specific job duties from 9/20/23 to 9/28/23. (See attachment).

On October 10, 2023, there was an all staff meeting for nursing staff on Behaviors and Behavioral Management, Abuse and Neglect Reporting, and Resident Rights. (attached). Staff member B was in attendance at this staff meeting. (attached).

On [REDACTED], an incident occurred where staff member B did not do rounds on the unit [REDACTED] was assigned to and left a resident unchanged the entire shift. Staff member B received a disciplinary action and a final warning for this incident. This incident was negligent and careless and Staff member B acknowledged understanding.

On [REDACTED] Staff member B was witnessed yelling at a resident in the memory care unit, grabbed resident's arm forcefully which left a bruise, and pushed a resident down into his wheelchair.

Staff member B was immediately terminated from employment for this incident. This incident was reported to the Department of Human Services, and the Pennsylvania Department of Aging according to Act 13 guidelines.

Family and physician were notified of the incident that occurred and were satisfied with the outcome. Physician examined the resident on his next visit to the community. Resident's bruises were healed at that time.

Going forward, the direct care staff and all staff will continue to be trained upon hire and frequently in all staff monthly meetings. The training will include behavior management and abuse reporting, as well as resident rights.

The Executive Director, Resident Care Manager (LPN) and the Assistant Resident Care Manager (LPN) will ensure compliance by continuing to educate all staff while doing walking rounds and coaching them in difficult resident behaviors. All managers of the community will also be observant of any behaviors in the community that may present a problem. Immediate action will be taken for any staff person that does not follow proper reporting and attention to the residents in the community.

**Licensee's Proposed Overall Completion Date: 12/21/2023**

42b Abuse (*continued*)

*Implemented* [REDACTED] - 12/26/2023)