pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

Located at **80 WEST MILLPORT ROAD, LITITZ, PA 17543**
(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

PROVISIONAL

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 **March 18, 2024** until **September 18, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **332981**

ISSUING OFFICER

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.

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: MARCH 18, 2024

Lititz PCH LLC
80 West Millport Road
Lititz, Pennsylvania 17543

RE: Legend Personal Care and Memory
Care of Lititz
80 West Millport Road
Lititz, Pennsylvania 17543
License #: 33298

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on December 12-13, 2023 and February 6, 2024 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 issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on our 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) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed.

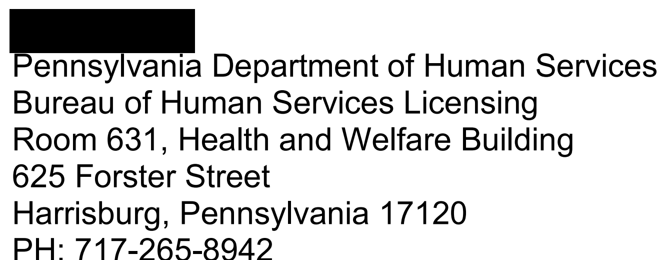
Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
2600.187(d)	II	70	$5	$350	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:



Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

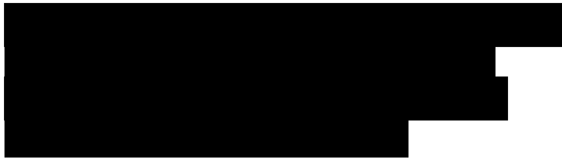
This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc:



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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LITITZ* **License #**: *33298* **License Expiration**: *11/15/2023*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA 17543*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *LITITZ PCH LLC*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA, 17543*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/07/2015* **Issued By**: *Warwick Township*

Type: *I-2* **Date**: *08/07/2015* **Issued By**: *Warwick township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *97* **Waking Staff**: *73*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *12/13/2023*

Inspection Dates and Department Representative

12/12/2023 - On-Site:

12/13/2023 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *66*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *40* **Residents Served**: *28*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *66*

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

Have Mobility Need: *31* **Have Physical Disability**: *0*

Inspections / Reviews

12/12/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/31/2023*

01/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/09/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/09/2024*

02/28/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/09/2024*

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 ███, Resident 3 had an unwitnessed fall in ███ bathroom. The resident's medical record confirms resident was found with a nosebleed and a bump on ███ head. Resident was subsequently transported to the hospital. The home did not submit an incident report to the Department.

In ███, Resident 1 reported the monetary loss of approximately $12,000 from ███ personal account to the home. The home did not report this incident to the department until 11/20/23.

On ███, Resident 1 reported the monetary loss of approximately $42,000 from ███ personal bank account to the home. The home did not submit an incident report to the Department.

Repeated Violation-1/4/23, et al

Plan of Correction ***Accept ███ - 01/02/2024)***

16 c WRITTEN INCIDENT REPORT
For identified residents, reportable events were submitted per requirements on 1-4-24. Additional incidents reviewed on12.29.23, no additional incidents identified that are outside of reporting requirements. Healthcare Specialist re-educated on APPENDIX B: Requirements and Best Practices for Reportable Incidents on 12.28.23 . RD, or designee, to review incident reports daily for 4 weeks, and then reevaluate if further monitoring is indicated., and RD to report anything to state per 2600.16c

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (███ - 02/12/2024)

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

Between November 2022 and April 2023, Staff Member A and B misappropriated a total of $12,000 from Resident 1's personal bank account.

Plan of Correction ***Accept (███ - 01/02/2024)***

42b ABUSE
For identified resident, incident report submitted to state on 11/20/2023. Re-educated associates regarding APS and resident rights on 1.4.23 . RD, or designee, to review communication log daily for 4 weeks, then monthly with

42b - Abuse (continued)

QMPI, and RD to report anything to state per state requirements

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (█ - 02/12/2024)

63a - First Aid/CPR Training

3. 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 11/28/23 and 12/2/23, from 10:00 pm to 6:00 am, there were approximately 63 residents in the home. During this time, 1 staff person was present in the home who was certified in CPR and First Aid.

On 12/5/23, from 10:00 pm to 6:00 am, there were approximately 63 residents in the home. During this time, there were no staff person present in the home who were certified in CPR and First Aid.

Plan of Correction ***Accept (█ - 01/02/2024)***

63a FIRST AID/TRAINING
The schedule was reviewed to check for 1:50 First Aid/CPR trained associate to resident ratio; first aid/CPR training to occur on 1.3.23 to train additional associates on first aid/CPR. Quarterly first aid/CPR training to occur going forward. RD, or designee, to review schedule a week in advance and update the schedule to have 1:50 1:50 First Aid/CPR trained associate to resident ratio per the requirement by 1.3.23.

Licensee's Proposed Overall Completion Date: *01/03/2024*

Implemented (█ - 02/12/2024)

82c - Locking Poisonous Materials

4. 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

On 12/12/23, a Colgate toothpaste container and a 2.6oz Secret solid deodorant with manufacture labels indicating "Keep out the reach of children. If accidently swallowed get medical help or contact a poison control center right away.", were unlocked, unattended, and accessible to Resident 5. Not all the residents of the home, including Resident 5, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials *(continued)*

Plan of Correction ***Accept (█ - 01/02/2024)***

82c LOCKING POISONOUS MATERIALS
Identified poisonous materials immediately secured per requirement upon survey exit on 12.14.23. RD, or designee, to do room checks weekly on memory care Apartments , for 4 weeks and then reevaluate if further monitoring is indicated. Re-educated associates on 1-4-24.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (█ - 02/12/2024)

85a - Sanitary Conditions

5. Requirements

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

Description of Violation

On 12/12/23, a pungent odor of urine was detected upon entry into resident room 323.

Plan of Correction ***Accept (█ - 01/02/2024)***

85a SANITARY CONDITIONS
Resident room was cleaned on 12.14.23. The bed was identified as the source and replaced on 12.29.23. RD, or designee, to do room checks weekly on memory care rooms for cleanliness and odor, for 4 weeks and then reevaluate if further monitoring is indicated. Re-educated associates on Sanitation guides on 1-4-24.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (█ - 02/12/2024)

85d - Trash Receptacles

6. 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 12/12/23 at 10:18 am, there was an uncovered and unattended trash can in the kitchen of the Secured Dementia Care Unit (SDCU).

Plan of Correction ***Accept (█ - 01/02/2024)***

85d TRASH RECEPTACLES
Trash can cover replaced immediately on 12.13.23. Maintenance Director (MD), or designee, to check trash receptacle for cover weekly throughout building, for 4 weeks and then reevaluate if further monitoring is indicated. Re-education of associates on keeping trash receptacle covered on 1-4-24.

Licensee's Proposed Overall Completion Date: *01/04/2024*

85d - Trash Receptacles *(continued)*

Implemented (- 02/12/2024)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 12/12/23, the food warmers and refrigerator located in the kitchenette of the Secured Dementia Care Unit (SDCU) were soiled with dried food and beverage stains.

Plan of Correction ***Accept (- 01/02/2024)***

88a Surfaces
Identified surfaces immediately cleaned on 12.13.23. MD, or designee, to check weekly on memory care steam table and fridge for cleanliness, for 4 weeks and then reevaluate if further monitoring is indicated. Re-educated associates on Surface guides on 1-4-24

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (- 02/12/2024)

102i - Soap Dispenser

8. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 12/13/23 at 10:13 am, there was an unlabeled bar of soap observed in the shower of shared resident bathroom in resident room 321 and 322.

Repeated Violation-1/4/23, et al

Plan of Correction ***Accept (- 01/02/2024)***

102i Soap Dispenser
Initiated individual resident soap dispensers on 12.14.23. RD, or designee, to do room checks weekly on memory care rooms with shared bathrooms, to have personal items in shared bathrooms labeled weekly for 4 weeks and then reevaluate if further monitoring is indicated. Re-educated associates on 1-4-24 on this regulation

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (- 02/12/2024)

103g - Storing Food

9. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

103g - Storing Food *(continued)*

Description of Violation

On 12/12/23, a slice of pie in the refrigerator located in the Secure Dementia Care Unit (SDCU) was opened and unsealed.

Plan of Correction ***Accept (- 01/02/2024)***

103g STORING FOOD

Identified food immediately disposed of on 12.13.23. Re-education of associates regarding food storage on 14.24. RD, or designee, to do checks weekly on memory care in the kitchen area to include the fridge for 4 weeks and then reevaluate if further monitoring is indicated. Food found to be stored improperly shall be disposed of immediately

Licensee's Proposed Overall Completion Date: *01/04/2024*

Not Implemented (- 02/12/2024)

105g - Lint Removal and Duct Cleaning

10. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 12/12/23, there was an approximate 1-inch accumulation of lint in the lint trap of the resident dryer near apartment A122. There were no clothes in the dryer at the time.

On 12/12/23, there was an approximate 2-inch accumulation of lint in the lint trap of the resident dryer near apartment A106. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 01/02/2024)***

105g LINT REMOVAL and DUCT CLEANING

Lint traps were immediately cleaned on 12.13.23. New signs posted on dryer in resident area laundry to remove lint. MD, or designee, to do weekly checks on resident dryers for 4 weeks and then reevaluate if further monitoring is indicated. Resident re-education to occur on 1.4.24 on importance of cleaning the lint trap.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (- 02/12/2024)

141a - Medical Evaluation

11. 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.

Description of Violation

Resident 2's initial medical evaluation (DME) was completed on However, Resident 2 was admitted to the home on

141a - Medical Evaluation (continued)

Repeated Violation-10/4/23, et al

Plan of Correction ***Accept (█ - 01/02/2024)***

141a MEDICAL EVALUATION
Current residents' medical evaluation audit completed and identified resident DMEs shall be corrected by 1.12.23. RD will re-educate sales director, or designee, on regulation 2600.141a on 1-4-24. RD. Sales director shall educate referrals on need for a medical evaluation completed with the required time frames. RD, or designee, shall validate compliance of medical evaluation prior to move-in

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (█ - 02/12/2024)

144c1 - Smoking Area Guidelines

12. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home has a no smoking policy. However, on 12/12/23, 9 cigarette butts were observed on the ground around the home's dumpsters.

Plan of Correction ***Accept (█ - 01/02/2024)***

144c1 SMOKING AREA GUIDELINES
Identified area cleaned immediately on 12.13.23. Re-educated associates that the campus is non-smoking and smoking is not permitted 1.4.23. Replaced No Smoking signage by trash can. MD, or designee, to monitor area by trash cans for cigarettes daily for 4 weeks and clean as needed; and then reevaluate if further monitoring is indicated.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Not Implemented (█ - 02/12/2024)

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 home's 2012 Buick transportation vehicle does not have a first aid kit.

171b5 - First Aid Kit *(continued)*

Plan of Correction ***Accept (█ - 01/02/2024)***

171b FIRST AID KIT

The community car, 2012 Buick was supplied with a first aid kit on 12.15.23. This first aid kit will have a zip tie to seal the container. If any driver utilizes the first aid supplies and breaks the zip tie it will be brought back into the community to replace the items used and resealed and replaced in the vehicle the same day. There will be an audit each time the vehicle is utilize to assure the first aid kit is in place. Re-education to the associates that are approved as driver of the vehicle on 1.4.23.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented (█ - 02/12/2024)

183e - Storing Medications

14. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

On 12/13/23, 3 loose pills were found in medication cart #2.

Repeated Violation-10/4/23, et al

Plan of Correction ***Accept (█ - 01/02/2024)***

183e STORING MEDICATIONS

The MT immediately destroyed pill found in the bottom of the cart #3 using the drug buster system on 12.13.23 The RD reeducated the MT's and LPNS of this Regulation 1.3.23. The HCD/AHCD/RD and or designee will audit the current med carts for loose medication weekly for of 4 weeks and monthly thereafter.

Licensee's Proposed Overall Completion Date: *01/03/2024*

Implemented (█ - 02/12/2024)

183f - Discontinued Medications

15. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

On 12/13/23, 2 boxes of CVS artificial tears (PRN), prescribed for Resident 2, were in the home's medication cart; however, the medication expired on 10/1/23.

Plan of Correction ***Accept (█ - 01/02/2024)***

183f DISCOUNTED MEDICATIONS

The expired natural tears were removed upon day of inspection and sent back to pharmacy for destruction on 12-13-23. Order was obtained to discontinue natural tear eyedrops. The HCD/AHCD/RD and or designee will conduct

183f - Discontinued Medications (continued)

cart audits monthly and ongoing for any expired (PRN) medication found. Reeducation on expired medications and proper deconstruction will be in 1.3.24. These audits will be kept by the HCD/AHCD in a binder. If any expired medications are identified they would then be removed and destroy properly and or re ordered if necessary. Soon to expire may also be replaced if necessary.

Licensee's Proposed Overall Completion Date: *01/03/2024*

Not Implemented (█ - 02/12/2024)

185a - Implement Storage Procedures

16. 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 is prescribed Acetaminophen 325mg, Nitroglycerin 0.4mg and Oxycodone HCL 5 as needed. On 12/13/23 these medications were not available in the home.

Resident 4 is prescribed Ondansetron and Saline Nasal Spray as needed. On 12/13/23 these medications were not available in the home.

Plan of Correction ***Accept (█ - 01/02/2024)***

185a IMPLEMENT STORAGE PROCEDURES
Resident #1 missing PRN Tylenol, Nitroglycerin, and Oxycodone were discontinued on 12.14.23 for lack of use. Resident #4 PRN Ondansetron and saline nasal spray that were found not available were (replaced by what 12.13.23) The RD reeducated the MT's on 1.3.23 on this regulation and are aware the need for PRN medication to be available to the resident. Pharmacy manifest sheets noted to be missing when receiving medications. These signed sheets upon deliver will be maintained in a binder and retained for 30 days. The AHCD/ HCD or designee, will monitor this process monthly

Licensee's Proposed Overall Completion Date: *01/03/2024*

Not Implemented (█ - 02/12/2024)

187d - Follow Prescriber's Orders

17. Requirements

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

Description of Violation

Resident 4 is prescribed blood sugar testing twice daily. However, Resident 4's blood sugar level was not tested on 12/1/23 at 6 am, 12/1/23 at 5 pm, 12/5/23 at 6 am and 12/10/23 at 6 am.

Resident 5 is prescribed 1 puff of Trelegy Ellipta 200 daily. However, this medication was not administered on 12/5/23 at 8 am.

Repeated Violation-10/4/23, et al and 1/4/23, et al

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

Plan of Correction ***Accept (- 01/02/2024)***

187d FOLLOW PRESCRIBER'S ORDERS

The physician was made aware of the refusal of glucose testing on 12.9.23. the MT responsible will be coached, counseled, and reeducated for these errors on 1.3.23. Resident # 5 medication error was submitted late for this missing a medication by 12-5.23. The MT responsible for this error . no longer with company. HCD/AHCD/RD and or designee will review this report for any medication discrepancy each day for 4 weeks and then reevaluate if further monitoring is indicated. For any additional error and submit any necessary report/ coaching additional education as needed.

Licensee's Proposed Overall Completion Date: *01/03/2024*

Not Implemented (- 02/12/2024)

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 2 has a bedside mobility device secured to the side of the bed. The support plan for Resident 2, dated does not indicate the need for this device.

Plan of Correction ***Accept (- 01/02/2024)***

227d SUPPORT PLAN MEDICAL/DENTAL

Resident #2 RASP will be updated by 1/5/23 with the necessary criteria of the bed mobility device, the intention of the use, the need for the device (specific device to be listed) ability to use and its safety, the risk, the resident ability to use safely and the need of a cover, if needed, due to FDA guidelines for additional safety. An Audit for the community was completed on for any additional mobility devices currently in the community to assure any RASP updates will be made when this audit is complete. Going forward any new Physician order for any mobility devices will be also detailed on the specific RASP as needed. The RD/HCD/AHCD will be reeducated on this regulation and criteria for the safe use of bed mobility devices on 1.3.23 by the RHCD. Any current resident needs for mobility devices will be updated in the RASP by 1-12-24

Licensee's Proposed Overall Completion Date: *01/12/2024*

Implemented (- 02/12/2024)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LITITZ* **License #**: *33298* **License Expiration**: *11/15/2024*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA 17543*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *LITITZ PCH LLC*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA, 17543*

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *08/07/2015* **Issued By**: *Warwick Township*

Type: *I-2* **Date**: *08/07/2015* **Issued By**: *Warwick Township*

Staffing Hours

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

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Interim* **Exit Conference Date**: *02/06/2024*

Inspection Dates and Department Representative

02/06/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *40* **Residents Served**: *31*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*

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

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

02/06/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/22/2024*

02/28/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/21/2024*

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

103g - Storing Food

1. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2/6/24 at approximately 10:00am, there was a large pitcher of a brown substance unsealed and not dated in the refrigerator.

Plan of Correction ***Directed (█ - 02/26/2024)***

Identified food immediately disposed of on 2.6.24. Re-education of associates regarding food storage completeby RD on 2.20.24. Chef to complete routine checks of storage area. Residence Director (RD), or designee, to do checks weekly on memory care in the kitchen area to include the fridge for 4 weeks and then reevaluate if further monitoring is indicated. Food found to be stored improperly shall be disposed of immediately.

Proposed Overall Completion Date: 02/29/2024

[Directed]

- *Starting on 3/4/24, the Chef will complete routine checks of the storage area.*
- *Starting on 3/4/24, Residence Director (RD), or designee, to do checks weekly on memory care in the kitchen area to include the fridge for 4 weeks and then reevaluate if further monitoring is indicated. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*

144c1 - Smoking Area Guidelines

2. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home has a no smoking policy. However, on 2/6/24, several cigarette butts were on the ground at the front entrance of the building and around the bench to the left of the building.

Plan of Correction ***Directed (█ - 02/26/2024)***

Identified area cleaned immediately on 2.6.24. Re-educated associates that the campus is non-smoking and smoking is not permitted completed by RD2.20.24. Maintenance Director (MD), or designee, to monitor area by trash cans for cigarettes daily for 4 weeks and clean as needed; and then reevaluate if further monitoring is indicated.

Proposed Overall Completion Date: 03/20/2024

144c1 - Smoking Area Guidelines (continued)

[Directed]

- *Starting on 3/4/24, Maintenance Director (MD), or designee, to monitor area by trash cans for cigarettes daily for 4 weeks and clean as needed; and then reevaluate if further monitoring is indicated. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*

183f - Discontinued Medications

3. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

Resident 3's PRN Voltaren (1%) gel expired on 12/2/23.

Plan of Correction ***Directed (█ - 02/26/2024)***

The PRN Voltaren (1%) gel was removed the day of inspection and sent back to pharmacy for destruction on 2/6/24 by HCD. Due to resident not using an order to discontinue order was obtained 2/20/24 by HCD. The Health Care Director/AHCD/RD and or designee will conduct cart audits monthly and ongoing for any expired (PRN) medication found. Associates passing medications were Re education on expired medications and proper destruction on 2.20.24 by RD. If any expired medications are identified they would then be removed and destroy properly. Protactively, soon to expire may also be replaced if necessary.

Proposed Overall Completion Date: 03/30/2024

[Directed]

- *Starting on 3/4/24, the Health Care Director/AHCD/RD and or designee will conduct cart audits monthly and ongoing for any expired (PRN) medication found. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*

185a - Implement Storage Procedures

4. 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 is prescribed Tylenol (500mg) as needed. On 2/6/24 this medication was not available in the home.

185a - Implement Storage Procedures (continued)

Resident 4 is prescribed Acetaminophen (500mg) and Ibuprofen (200mg) as needed. On 2/6/24 these medications were not available in the home.

Plan of Correction **Directed (- 02/26/2024)**

Resident #1 missing PRN Tylenol, was not available on 2/6/24. On 2/20/24 order was obtained to d/c medication. This resident has been out of the facility . Resident #4 missing acetaminophen and ibuprofen as needed order. On 2/6/24 obtained an order through the physician, resident also self-administers. The RD reeducated the Medication Tech's on 2.20.24 on this regulation and are aware the need for PRN medication to be available to the resident.

Proposed Overall Completion Date: 03/30/2024

[Directed]

- *Starting on 3/4/24, the Health Care Director/AHCD/RD and or designee will conduct cart audits monthly and ongoing to ensure PRN medications are available on-site. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*

187d - Follow Prescriber's Orders

5. Requirements

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

Description of Violation

Resident 2 is prescribed Cavilon barrier cream daily, Duloxetine HCL (60mg) daily, Finasteride (5mg) daily, Spironolactone (25mg) daily and Trulicity (1.5mg/0.5) to be administered once a week. However, these medications were not administered to the resident on 2/6/24 because the medications were not available in the home.

Resident 1 is prescribed Allopurinol (300mg) daily. However, this medication was not administered to the resident on 1/15, 1/16 and 1/17/24 because the medications were not available in the home.

Resident 5 is prescribed Timolol (0.5%) eye drops twice daily. However, this medication was not administered to the resident on 1/23, 1/24, 1/30/24 at 8:00am and on 1/23 and 1/28/24 at 8:00pm because the medications were not available in the home.

Repeated Violation-10/4/23, et al and 1/4/23, et al

Plan of Correction **Directed (- 02/26/2024)**

Resident # 2 did receive the prescribed medications, was at the last doses. There was a renewal order placed on 2.6.24, which came that night for the next morning dosage. There was an order to discontinue sent 2.6.24 for Resident #1 to d/c the allopurinol since has . Resident #5 pharmacy was called and

187d - Follow Prescriber's Orders (continued)

reportable was completed on 2-20-2024 by this RD. HCD/AHCD/RD and or designee will review this report for any medication discrepancy each day for 4 weeks and then reevaluate if further monitoring is indicated. For any additional error and submit any necessary report/ coaching additional education as needed.

Proposed Overall Completion Date: 03/30/2024

[Directed]

- *Starting on 3/4/24, HCD/AHCD/RD and or designee will review this report for any medication discrepancy each day for 4 weeks and then reevaluate if further monitoring is indicated. For any additional error and submit any necessary report/ coaching additional education as needed. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*

231c - Preadmission Screening

6. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. However, the resident's written cognitive preadmission screening was not completed.

Repeated Violation-3/15/23

Plan of Correction ***Directed ([redacted] - 02/26/2024)***

Resident #5 cognitive preadmission screen was found not to be completed and fixed immediately by the AHCD on 2.6.24. Current resident's preadmission screens reviewed on 2.20.24 by HCD and ensured screens to be complete. Will continue to monitor new admissions weekly for 4 weeks to ensure the cognitive preadmission screening is completed within 72 hours prior admission for any memory care resident. Will also complete any cognitive screen the day before for any resident transferring to Memory care neighborhood from Personal Care neighborhood.

Proposed Overall Completion Date: 03/30/2024

[Directed]

- *Starting 3/4/24, RD and or designee will monitor new admissions weekly for 4 weeks to ensure the cognitive preadmission screening is completed within 72 hours prior admission for any memory care resident. Documentation of these audits should be kept and available for review by the Department.*

Directed Completion Date: *03/30/2024*