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

January 29, 2024

[redacted], ADMINISTRATOR
LEEDS HEALTH CARE SERVICES INC
[redacted]

RE: HEATHER COURT
281 IRONSTONE DRIVE
NORTHUMBERLAND, PA, 17857
LICENSE/COC#: 22706

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/19/2023, 12/20/2023 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]
Acting Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HEATHER COURT* **License #**: *22706* **License Expiration**: *12/29/2023*

Address: *281 IRONSTONE DRIVE, NORTHUMBERLAND, PA 17857*

County: *NORTHUMBERLAND* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *LEEDS HEALTH CARE SERVICES INC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/21/2017* **Issued By**: *NECU*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *70* **Waking Staff**: *53*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *12/20/2023*

Inspection Dates and Department Representative

12/19/2023 - On-Site: [redacted]

12/20/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *35*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Entire Home* **Capacity**: *48* **Residents Served**: *35*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *35*

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

Have Mobility Need: *35* **Have Physical Disability**: *0*

Inspections / Reviews

12/19/2023 Full

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

01/04/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *12/29/2023*

Inspections / Reviews *(continued)*

01/29/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/27/2024*

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

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

The enabler bar for Resident 1 & Resident 3 were not securely attached to the bed frame. posing as a possible hazard to residents.

Plan of Correction ***Accept (- 01/04/2024)***

Enabler bars for residents #1 and #3 have been secured to residents' beds as of 12/27/23. Monthly audits of enabler bars in use will be completed by Nursing Supervisor to insure enablers are safely secured to beds. See attached photos. Audits will continue until 100% accuracy is met for three consecutive months. See attached audit tool. Administrator will conduct spot checks to insure audit completion. See attached administrator audit tool

Proposed Overall Completion Date: 12/27/2023

Effective immediately the home will ensure that all enabler bars are properly covered to prevent entrapment by resident. The administrator shall monitor for ongoing compliance. 1/4/2024

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented (- 01/29/2024)

82a - Poisonous Materials

2. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

The laundry rooms were found to have laundry detergent being stored in clear Tupperware containers that did not include the manufacture's label.

Plan of Correction ***Accept - 12/29/2023)***

Clear Tupperware containers holding laundry detergents have been removed from laundry room as of 12/27/23 and original containers are in place. See attached photo. Weekly audits will be conducted by the administrator to insure that detergents are stored in original containers with manufacturer's labels. Audits will continue until 100% efficiency is reached for eight consecutive weeks. See attached administrator audit tool.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented 01/29/2024)

185a - Implement Storage Procedures

3. 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 2 is prescribed orally every 6 hours as needed. At the time of

185a Implement Storage Procedures (continued)

inspection on 12/20/2023, this PRN medication was not available.

Plan of Correction ***Accept (- 12/29/2023)***

Medication received on 12/20/23. See attached delivery receipt and medication photos. Nursing Supervisor will conduct weekly audit to insure PRN medication is present. See attached audit tool. Audits will continue until 100% accuracy is achieved for six consecutive weeks. Administrator will spot check audits every other week for completion. See attached administrator audit tool.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented - 01/29/2024)

227g -Support Plan Signatures

4. 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 3's RASP dated was not signed by the resident or the assessor.

Plan of Correction ***Accept (- 12/29/2023)***

Resident #3's current RASP was signed on . See attached RASP. RASP reviews will be completed by Nursing Supervisor on 5 randomly selected residents per month. Reviews will continue until there are no errors for 3 consecutive months. See attached audit tool. Administrator will spot check audit monthly for completion. See attached administrator audit tool.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented - 01/29/2024)

234a - Admission Support Plan

5. Requirements

2600.
234.a. Within 72 hours of the admission, or within 72 hours prior to the resident's admission to the secured dementia care unit, a support plan shall be developed, implemented and documented in the resident record.

Description of Violation

Resident 4 was admitted to the SDU on . There was no support plan completed as of .

Plan of Correction ***Accept - 01/04/2024)***

Resident #4's 3 day RASP was signed on . See attached RASP. RASP was completed in a timely manner, but RASP had not been turned into administrator at the time the inspection happened. RASP reviews will be completed by Nursing Supervisor on 5 randomly selected residents per month. Reviews will continue until there are no errors for 3 consecutive months. See attached audit tool. Administrator will spot check audit monthly for completion. See attached administrator audit tool.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented (- 01/29/2024)

234b - Support Plan Needs Elements

6. Requirements

234b - Support Plan Needs Elements *(continued)*

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The RASP of Resident 3 dated [redacted] was not updated to show that the resident is utilizing an enabler bar on their bed.
Repeat Violation 1/5/2023.

Plan of Correction ***Accept ([redacted] - 12/29/2023)***

Resident #3's RASP was updated on [redacted] See attached RASP. RASP reviews will be completed by Nursing Supervisor on 5 randomly selected residents per month. Reviews will continue until there are no errors for 3 consecutive months. See attached audit tool. Administrator will spot check audit monthly for completion. See attached administrator audit tool.

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented ([redacted] - 01/29/2024)

236 - Staff Training

7. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

There was only verification that Staff Member A completed 15.5 training hours in the 2022 training year.

Plan of Correction ***Accept [redacted] - 01/02/2024)***

It has been discovered prior to inspection that the training plan for some employees was not set up correctly it the course module. This issue had already been remedied for the 2023 year. Annual trainings are assigned to staff on a quarterly basis. Administrator will conduct quarterly audits to insure annual training courses are being completed in a timely manner. See attached audit tool. Audits will continue until 100% completion is met for two consecutive months

Licensee's Proposed Overall Completion Date: *12/27/2023*

Implemented [redacted] - 01/29/2024)