

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

May 21, 2024

[REDACTED], CEO
THE BETHLEN HOME OF HUNGARIAN REFORMED FEDERATION OF AMERIC
2018 ROUTE 30 EAST
LIGONIER, PA, 15658

RE: LIGONIER GARDENS
2018 ROUTE 30 EAST
LIGONIER, PA, 15658
LICENSE/COC#: 42805

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/01/2024, 02/02/2024 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: LIGONIER GARDENS License #: 42805 License Expiration: 11/10/2024
 Address: 2018 ROUTE 30 EAST, LIGONIER, PA 15658
 County: WESTMORELAND Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: THE BETHLEN HOME OF HUNGARIAN REFORMED FEDERATION OF AMERIC
 Address: 2018 ROUTE 30 EAST, LIGONIER, PA, 15658
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 12/22/1999 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 60 Waking Staff: 45

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint, Incident Exit Conference Date: 02/09/2024

Inspection Dates and Department Representative

02/01/2024 - On-Site: [REDACTED]
 02/02/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 71 Residents Served: 48
 Secured Dementia Care Unit
 In Home: No Area: Capacity: Residents Served:
 Hospice
 Current Residents: 8
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 47
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 12 Have Physical Disability: 1

Inspections / Reviews

02/01/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/17/2024

03/26/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/22/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/28/2024

Inspections / Reviews *(continued)*

04/10/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/22/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/24/2024

05/21/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/22/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

65i Training Record

1. Requirements

2600.

65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include the length of each course.

Plan of Correction

Accept () - 04/10/2024

- 1. All direct care staff training records will now include length of each course. Report was updated.
- 2. Current patients have the potential to be affected. The Administrator will review current staff members and ensure each staff training has length of course documented. Corrective action will be taken for any identified issues. Outcome of audit documentation to be kept by Administrator.
- 3. The administrator and/or designee to educate managers who provide direct care staff trainings on regulation 65.i. by 3/13/2024. Documentation of the education will be kept by the administrator.
- 4. The administrator and/or designee will conduct 3 staff training audits per week beginning 3/18/2024, for one month. After that month, the administrator will conduct 3 staff training audits per month to ensure proper documentation is completed for staff trainings. Documentation of the audits will be kept by the Administrator. Results of this audit will be shared at the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024

85e Trash Outside Home

2. Requirements

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 2/1/24, the lid of the dumpster was open, and there was trash extending above the top edge of it.

Plan of Correction

Accept () - 04/10/2024

- 1. The lid to the dumpster was immediately closed once identified during survey by RCC.
- 2. All patients have the potential to be affected. Housekeeping and/or designee will conduct daily walking rounds starting 3/15/2024 to ensure lid to dumpster is closed. Corrective action will be taken if identified as open or full. Housekeeping to keep record of daily rounds.
- 3. Administrator and/or designee will educate housekeeping staff on regulation 85.e. by 3/14/2024. Administrator to keep record of education.
- 4. The administrator and/or designee will meet with housekeeping once a week starting on 3/18/2024 to review outcome of walking round audits. Documentation of weekly meetings will be kept by the administrator. Outcomes of the audit will be shared at the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024

85e - Trash Outside Home (continued)

132c - Fire Drill Records

3. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill conducted on 3/14/23 at 5:13 AM did not document the amount of time it took for evacuation, the exit routes used, or whether or not the fire alarm or smoke detector was operative.

The home did not document the complete evacuation time to include minutes and seconds for fire drills on 11/13/23 at 11:37 AM and 1/25/24 11:02 AM.

REPEAT VIOLATION: 7/26/2022 et. al.

Plan of Correction

Accept () - 03/26/2024)

1. Facility is now completing all fire drill documentation per regulation 132.c.
2. All patients have the potential to be affected. Fire Drill to be completed on 3/20/2024. Maintenance and/or designee will ensure fire drill documentation is completed per regulation 132.c. Fire Drill documentation will be kept by maintenance and/or designee.
3. Administrator and/or designee will educate maintenance staff on regulation 132.c. by 3/15/2024. Documentation of education to be kept by administrator.
4. The Administrator and/or designee will complete audits once a month starting 4/1/2024 to ensure fire drill documentation are completed per regulation 132.c. Outcomes of that audit will be kept by the Administrator and shared during the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024)

132d - Evacuation

4. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

No residents were evacuated to a public thoroughfare or to a fire-safe area during the fire drill conducted on 3/14/23 at 5:13 AM.

REPEAT VIOLATION: 7/26/2022 et. al.

132d Evacuation (continued)

Plan of Correction

Accept () - 04/10/2024)

- 1. Facility is now evacuating all residents to public thoroughfare or to a fire safe area during fire drills.
- 2. All patients have the potential to be affected. Fire Drill to be completed on 3/20/2024, Maintenance and/or designee will ensure full evacuation is held during fire drill. Documentation of the fire drill and evacuation to be kept by maintenance and/or designee.
- 3. Administrator and/or designee will educate all staff on regulation 132.d. by 4/3/2024. Documentation of education to be kept by administrator.
- 4. The Administrator and/or designee will complete monthly audits starting 4/3/2024 to ensure patients are evacuated to a public thoroughfare or to a fire safe area during fire drills. Outcomes of that audit will be kept by the Administrator and shared during the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024)

132i - Testing Fire Alarm

6. Requirements

2600.

132.i. A fire alarm or smoke detector shall be set off during each fire drill.

Description of Violation

The home did not set off a fire alarm or a smoke detector during the fire drill on 3/14/23 at 5:13 AM.

Plan of Correction

Accept () - 03/26/2024)

- 1. Facility is now setting off fire alarm or smoke detector per regulation 132.i.
- 2. All patients have the potential to be affected. Fire Drill to be completed on 3/20/2024. Maintenance and/or designee will ensure fire alarm or smoke detector is set off during fire drill. Documentation of the fire drill to be kept by maintenance and/or designee.
- 3. Administrator and/or designee will educate maintenance staff on regulation 132. i. by 3/15/2024. Documentation of Education to be kept by administrator.
- 4. The Administrator and/or designee will complete monthly audits starting 4/1/2024 to ensure fire alarms or smoke detectors are set off during fire drills. Outcomes of that audit will be kept by the Administrator and shared during the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024)

181c - Self-administration Assessment

7. Requirements

2600.

181c - Self-administration Assessment (continued)

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

Resident #1 self-administers [redacted] in accordance with a sliding scale; however resident #1 has not been assessed by a physician, physician's assistant, or certified registered nurse practitioner regarding the ability to self-administer.

Plan of Correction

Accept [redacted] - 03/26/2024)

1. Resident #1 was assessed by physician or [redacted] and is permitted to self-administer [redacted] and sliding scale insulin.
2. All patients have the potential to be affected. Audit to be completed by Resident Care Coordinator with current residents and their ability to self-administer medications by 3/19/2024. Corrective actions will be taken if any patients are identified to self-administer medications and assessments are not completed. Outcome of this audit will be kept by the Resident Care Coordinator.
3. Administrator and/or designee will educate Resident Care Coordinator on regulation 181.c. By 3/14/2024. Documentation of the education will be kept with Administrator.
4. Resident Care Coordinator will conduct twice a month audits for 3 months then monthly thereafter starting 3/25/2024 to ensure assessments are being completed on any resident who can self-administer medications. Outcomes of these audits will be kept by the Resident Care Coordinator and shared during the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented [redacted] - 05/17/2024)

183b - Meds and Syringes Locked

8. 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

Resident #1 is prescribed [redacted] by sliding scale. On [redacted] at approximately [redacted] [redacted] was left unlocked and unattended on the nightstand in [redacted].

REPEAT VIOLATION: 7/26/2022 et. al.

Plan of Correction

Accept [redacted] - 04/10/2024)

1. Resident #1 was given a key for [redacted] room by Administrator on 2/1 and prescription medication is now locked up.
2. All patients have the potential to be affected. Resident Care coordinator will complete audit for current residents who self-administer medications to ensure medications are in a locked area when not in use by 3/19/2024. Corrective action to be taken if any issues are identified. Resident Care Coordinator will keep record of audit.
3. Administrator and/or designee will educate both Resident Care Coordinator and Resident #1 on regulation 183.b. by 3/19/2024. Documentation of education will be kept by Administrator.
4. Resident Care Coordinator will conduct twice a week audits for 1 month and then monthly thereafter starting 3/25/2024 to ensure residents who self-administrate medication have all medications in a locked area when not in

183b - Meds and Syringes Locked (continued)

use. Outcomes of these audits will be kept by Resident Care Coordinator and shared during the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024)

183e - Storing Medications

9. 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

Resident #2 was prescribed [redacted] by mouth every 8 hours as needed for pain. This medication was present in the home on [redacted] however, it was discontinued on [redacted]

Plan of Correction

Accept () - 04/10/2024)

- 1. Medication for Resident #2 was removed from cart and properly destroyed by RCC and Medtech.
- 2. All patients have the potential to be affected. Resident Care Coordinator and/or designee to conduct a med cart audit by 3/22/2024 to determine if any other medications are expired and/or discontinued. Corrective action will be taken for any identified issues. Documentation of audit will be kept by Resident Care Coordinator.
- 3. Administrator and/or designee will educate Resident Care Coordinator and Med Techs on regulation 183.e by 4/4/24. Documentation of this education will be kept by the Administrator.
- 4. Resident Care Coordinator will complete weekly med cart audits for one month, then monthly thereafter starting 3/25/2024 to ensure medications are not expired and/or discontinued. Documentation of this audit will be kept by the Resident Care Coordinator and shared with the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented () - 05/17/2024)

184a - Resident's Meds Labeled

10. Requirements

2600.

- 184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
 - 1. The resident's name.
 - 2. The name of the medication.
 - 3. The date the prescription was issued.
 - 4. The prescribed dosage and instructions for administration.
 - 5. The name and title of the prescriber.

Description of Violation

There was no pharmacy label on resident #3's [redacted].

184a Resident's Meds Labeled (continued)

Resident #3 is prescribed [redacted] 1 tablet daily; however, the label indicates the resident takes [redacted] 1 tablet daily.

Resident #4 is prescribed [redacted] 1 tablet by mouth daily; however, the label indicates the resident takes [redacted] 1 tablet daily.

REPEAT VIOLATION: 7/26/2022 et. al.

Plan of Correction

Accept [redacted] - 04/10/2024)

1. Resident #3 and Resident #4's pharmacy labels are now present and match physician orders. RCC contacted pharmacy and resolved 2/1.
2. All patients have the potential to be affected. Resident Care Coordinator will complete med cart audits by 3/22/2024 to ensure pharmacy labels are on medications. Corrective Actions will be taken if any issues identified. Outcome of audit will be kept by Resident Care Coordinator.
3. Resident Care Coordinator will complete audits on 25 residents to ensure pharmacy label and physician orders match by 3/31/2024. Corrective action will be taken if any issues identified. Outcome of audit will be kept by Resident Care Coordinator.
4. Administrator and/or designee will educate Resident Care Coordinator and Med Techs on regulation 184.a. by 3/22/2024. Documentation of education will be kept by Administrator.
5. Resident Care Coordinator will audit 5 residents a week for one month and then 5 residents biweekly thereafter starting 4/8/2024 to ensure pharmacy labels and physician orders match. Outcome of these audits will be kept by the Resident Care Coordinator and shared with the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024

Implemented [redacted] 05/17/2024)

185a - Implement Storage Procedures

11. 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 [redacted] 2 puffs every 8 hours as needed for cough or shortness of breath; however, on 2/2/24 this medication was not available in the home.

Resident #5 is prescribed [redacted] 1 spray in each nostril twice daily as needed for nasal congestion; however, on 2/1/24 this medication was not available in the home.

REPEAT VIOLATION: 7/26/2022 et. al.

185a Implement Storage Procedures (continued)**Plan of Correction****Accept ([REDACTED] - 04/10/2024)**

1. Medications are now available for Resident #2 and Resident #5. Pharmacy contacted by RCC and delivered.
2. All patients have the potential to be affected. Resident Care Coordinator will audit 25 residents to ensure medications are available in the home by 3/31/2024. Corrective action will be taken if any issues are identified. Outcomes of these audits will be kept by the Resident Care Coordinator.
3. Administrator and/or designee will educate both Resident Care Coordinator and Med Techs on regulation 185.a. Documentation of the education will be kept by the Administrator.
4. Resident Care Coordinator will audit 5 residents a week for one month and then 5 residents biweekly thereafter starting 4/8/2024 to ensure medications are available in the home. Outcome of these audits will be kept by the Resident Care Coordinator and shared with the Quality Assessment and Assurance Committee meeting on 4/12/2024. Documentation of meeting will be kept by the Administrator.

Licensee's Proposed Overall Completion Date: 04/19/2024**Implemented ([REDACTED] - 05/17/2024)**