

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

April 22, 2024

[REDACTED]
REGAL MANOR LLC
[REDACTED]

RE: THE LELAND OF LAUREL RUN
120 WEST MAIN STREET
WAYNESBORO, PA, 17268
LICENSE/COC#: 32994

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/22/2024, 03/08/2024 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: *THE LELAND OF LAUREL RUN* License #: 32994 License Expiration: 11/26/2024
 Address: 120 WEST MAIN STREET, WAYNESBORO, PA 17268
 County: FRANKLIN Region: CENTRAL

Administrator

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

Legal Entity

Name: REGAL MANOR LLC
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 09/25/2012 Issued By: Boro of Waynesboro

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 94 Waking Staff: 71

Inspection Information

Type: Partial Notice: Unannounced BHA Docket #:
 Reason: Complaint, Incident Exit Conference Date: 03/08/2024

Inspection Dates and Department Representative

02/22/2024 - On-Site: [REDACTED]
 03/08/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 80 Residents Served: 74
 Secured Dementia Care Unit
 In Home: Yes Area: Fourth Floor Capacity: 22 Residents Served: 20
 Hospice
 Current Residents: 8
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 74
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 20 Have Physical Disability: 1

Inspections / Reviews

02/22/2024 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/01/2024

03/29/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 04/19/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 04/08/2024

Inspections / Reviews *(continued)*

04/15/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/19/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/22/2024

04/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/19/2024

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

Resident [REDACTED], admitted on [REDACTED], has engaged in inappropriate [REDACTED] behaviors towards other residents. On [REDACTED] Resident [REDACTED] entered a shower room when a [REDACTED] was bathing. Resident [REDACTED] would not leave the shower room when asked by staff and the resident. On [REDACTED] and [REDACTED] Resident [REDACTED] entered shower/spa rooms when [REDACTED] residents were bathing. On [REDACTED], Resident [REDACTED] entered 3 different [REDACTED] resident rooms and lifted up their covers while verbally expressing [REDACTED] "wanted to take them to bed". These incidents "had made many of them uncomfortable and upset". On [REDACTED] at approximately [REDACTED], Resident [REDACTED], entered Resident [REDACTED] room and touched Resident [REDACTED] on the inner thighs and private areas. Resident [REDACTED] is on hospice, has a hospital bed, is confined to a wheelchair and has a primary diagnosis of [REDACTED]. Both residents resided in the [REDACTED] of the home at the time of the incident.

In the evening of [REDACTED], Staff Member A used his/her body to forcefully require Resident [REDACTED] to sit on the commode to perform evening cares against Resident [REDACTED] wishes. Staff Member A physically pried Resident [REDACTED] hand off of the arms of the wheelchair that the resident was using to steady [REDACTED] balance and then pushed the wheelchair out of the resident's reach.

Plan of Correction

Directed [REDACTED] - 04/15/2024)

(Directed)

- The facility cannot retroactively correct the situation regarding Resident [REDACTED]. The facility recognizes that all residents have the potential to be affected. The facility will continue to provide care and services to attain or maintain the highest physical, mental, and psychosocial well-being of all residents. Please see system changes and monitoring measures for corrective actions.
- Resident [REDACTED] was immediately redirected by staff when entering shower rooms or when wandering into [REDACTED] resident's rooms. On [REDACTED], Psych CRNP was notified to review resident's behaviors and medications. On [REDACTED], the resident was ordered Depakote sprinkles for adjustment disorder with disturbance of conduct. On [REDACTED], the Depakote was increased to [REDACTED]. On [REDACTED], the same day the incident occurred, the [REDACTED] was notified the facility would be giving a 30-day discharge notice. Resident [REDACTED] was immediately assessed when the staff saw resident [REDACTED] coming out of [REDACTED] room, and no negative outcomes were identified. The family was offered to send resident [REDACTED] to the ER for evaluation, but they declined. Immediately after the incident occurred, resident [REDACTED] was placed on strict 1:1 and remained on strict 1:1, 24 hours a day until [REDACTED] exited the building at the time of [REDACTED] discharge on [REDACTED], to ensure the safety of all residents.
- An in-service was immediately implemented for staff regarding how to address suspicious behaviors of residents and placing residents on 1:1 when needed to ensure the safety of all residents. Staff were also in-serviced on the types of abuse, abuse reporting and preventing abuse. Ongoing in-servicing will be conducted and completed by [REDACTED]. Relias training for March 2024 included "Safeguarding resident rights in nursing facilities," which also reviewed abuse reporting. All staff are required to complete the training and will be monitored for completion by the HR Director/ and or designee. Staff not completing this training by [REDACTED] will be required to meet with the Administrator/ and or designee, to ensure completion of the

42b - Abuse (continued)

Relias training.

- Ten random 24-hour reports have been reviewed on [REDACTED] to audit if the 24-hour reports reflected residents noted to have had condition changes or behavioral issues, and that there was appropriate follow-up. On going weekly review of shift reports will be conducted starting [REDACTED] by the Administrator/ and or designee and will continue to review three 24-hour reports weekly through [REDACTED], to ensure all changes/issues are addressed promptly and appropriately.
- Nursing notes will be reviewed daily beginning [REDACTED] by the Unit Managers or Administrator to detect any behavioral issues, and appropriate interventions are in place through [REDACTED]. Through these audits, the facility will ensure that each resident receives adequate supervision with an individualized plan of care to meet the specific needs of each resident.
- Daily walking rounds will begin on [REDACTED] by Managers/ and or designee, and round sheets for the Personal care unit and the Memory care unit have been updated, to include monitoring for behaviors, and ensuring appropriate interventions are in place. Round sheets will be turned into the Administrator weekly for review through June 30th, 2024. Education will be provided as issues are identified.
- A new full-time activity staff member has been hired specifically for the Memory Care unit, to ensure adequate programming is being provided to the dementia residents, and to assist in decreasing behaviors.
- The facility cannot retroactively correct the situation regarding Resident [REDACTED]. The facility recognizes that all residents have the potential to be affected. The resident reported the incident on the afternoon of [REDACTED], stating the incident occurred on the previous evening shift. Resident [REDACTED] was added to acute charting to monitor for adverse effects from the incident and the POA and MD were notified. Staff member A was not on duty at the time the incident was reported, however, staff member A was notified that she needed to come in and speak with the Administrator and Director of Wellness. Staff member A came to the facility the following day and gave a written statement and was interviewed by the Administrator and the Director of Wellness. Staff member A was told at that time that [REDACTED] would be suspended pending an investigation. A thorough review was conducted by the Administrator and the Director of Wellness and reported to the Owner of the facility. The investigation determined that the facility would terminate staff member A's position, and staff member A was notified of the decision on [REDACTED].
- When the incident was reported to staff, an in-service was immediately initiated to educate staff on prompt reporting of suspicions of abuse and the types of abuse. A review of resident rights was also conducted at this time. On going in-servicing will be conducted and completed by the Administrator/ and or designee by [REDACTED].
- The 24-hour report audits and nursing notes, mentioned in the first incident, were also reviewed for appropriate interventions/responses from nursing staff to assist with identifying behaviors, and to ensure appropriate responses were initiated by staff. On going weekly review of shift reports will be conducted by the Administrator/ and or designee and will continue to review three 24-hour reports weekly from [REDACTED] through [REDACTED], to ensure all changes/issues are addressed promptly and appropriately and to identify any issues of concern with staff responses.
- Daily walking rounds will begin on [REDACTED] and will be done by Managers/ and or designee, and round sheets for the Personal care unit and the Memory care unit have been updated to include monitoring for behaviors, and ensuring appropriate interventions are in place, as well as observing for appropriate interventions between staff and residents. Round sheets will be turned into the Administrator weekly for review through [REDACTED]. Education will be provided as issues are identified.

42b - Abuse (continued)

Proposed Overall Completion Date: 06/30/2024

Directed Completion Date: 06/30/2024

Implemented [REDACTED] - 04/22/2024)

202 - Prohibitions

2. Requirements

2600.

202. The following procedures are prohibited:

- 4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident [REDACTED] is prescribed medication to control episodic behaviors as described in the following orders:

The order, received on [REDACTED], prescribed [REDACTED].
 [REDACTED] Give 1 capsule by mouth two times a day for Behaviors. On [REDACTED], a new order was received prescribing [REDACTED]. Give 2 capsules by mouth two times a day for Behaviors."

Plan of Correction

Directed [REDACTED] 04/15/2024)

(Directed)

- The facility could not retroactively correct the situation regarding Resident [REDACTED] as [REDACTED] orders had been discontinued since [REDACTED] has been discharged from the facility.
- An in-service was immediately held with the LPN on [REDACTED] that incorrectly ordered [REDACTED] with a diagnosis of behaviors. All other licensed staff will have in-servicing completed by [REDACTED] to review the definition of a chemical restraint, and to ensure that medications are not utilized for the exclusive purpose of controlling acute or episodic aggressive behavior.
- The Pharmacy Consultant was contacted by the Director of Wellness on [REDACTED]. The Pharmacy Consultant was notified that the facility is requesting that all Psychotropic medications and their diagnoses be reviewed for accuracy. The Pharmacy Consultant completed this audit on [REDACTED].
- Ongoing monitoring of Psychotropic medications and checking for appropriate diagnosis will be done by the Administrator. Five residents with Psychotropic medications will be audited weekly beginning [REDACTED] through [REDACTED] and corrections made as needed.

Proposed Overall Completion Date: 06/30/2024

Directed Completion Date: 06/30/2024

Implemented [REDACTED] 04/22/2024)