

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

April 17, 2024

[REDACTED], ADMINISTRATOR  
THE MENNONITE HOME  
1520 HARRISBURG PIKE  
LANCASTER, PA, 17601

RE: THE MENNONITE HOME  
1520 HARRISBURG PIKE  
SUSQ FL 1-3 & 5  
LANCASTER, PA, 17601  
LICENSE/COC#: 32178

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/19/2024 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 MENNONITE HOME License #: 32178 License Expiration: 02/08/2025  
 Address: 1520 HARRISBURG PIKE, SUSQ FL 1 3 & 5, LANCASTER, PA 17601  
 County: LANCASTER Region: CENTRAL

**Administrator**

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

**Legal Entity**

Name: THE MENNONITE HOME  
 Address: 1520 HARRISBURG PIKE, LANCASTER, PA, 17601  
 Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: I-2	Date: 04/03/2012	Issued By: L & I
Type: I-2	Date: 12/02/2021	Issued By: Manheim Township
Type: I-2	Date: 03/22/2022	Issued By: Manhem Township

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 64 Waking Staff: 48

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #: 0  
 Reason: Renewal Exit Conference Date: 03/19/2024

**Inspection Dates and Department Representative**

03/19/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: 85 Residents Served: 48

**Secured Dementia Care Unit**

In Home: Yes Area: Anderson Run Capacity: 21 Residents Served: 16

**Hospice**

Current Residents: 1

**Number of Residents Who:**

Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 48
Diagnosed with Mental Illness: 1	Diagnosed with Intellectual Disability: 0
Have Mobility Need: 16	Have Physical Disability: 0

**Inspections / Reviews**

03/19/2024 Full

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

Inspections / Reviews *(continued)*

04/05/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/12/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 04/12/2024

04/17/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/12/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

85d - Trash Receptacles

1. 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 3/19/24, there were 2 full, uncovered, unattended trash cans in the dining rooms of the secured dementia care unit (SDCU).

Plan of Correction

Accept (████) - 04/05/2024)

Plan :

Immediate plan : Open trash receptacles that are attached to bussing carts will need removed from bussing carts when not in use by staff in Dining Room. Trash can to be stored empty, placed on side inside of bussing cart on bottom shelf. Each can is to be emptied immediately after bussing tables and stored on its side on shelf until next service is needed.

Education provided to staff as evidenced by signed education sheet as to plan for keeping uncovered bussing trash cans empty and removed from cart when not being used to bus tables.

Education provided to Team members on PC households and Audit will be done by PCHA weekly to ensure procedure is being followed and reported on Monthly QAPI report .

Audit to start the week of April 8th by the DOPC and first QAPI report will be in the May 2024 meeting. see attached audit sheet

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

Implemented (████) - 04/16/2024)

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 3/19/24, 2 out of the 3 outside dumpsters were uncovered.

Plan of Correction

Accept (████) - 04/05/2024)

Plan:

Dining staff will monitor outside dumpster lids for coverage to prevent the penetration of insects and rodents on an on going basis. If found to be unsecure they will secure at the time of am and pm daily inspection to start on Friday April 5th , 2024 .

Attached please find education on need to keep dumpsters lids secure presented to Dining staff on 4/3/2024 and an audit form that will be completed daily by assigned MH Dining staff to start on April 5th , 2024 .

Form will be reviewed and reported on monthly in QAPI report by Dining Services Director starting in May , 2024 for compliance

Director of Personal CARE to review monthly for compliance starting in May , 2024 at QAPI .

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

Implemented (████) - 04/16/2024)

85e - Trash Outside Home (continued)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.

101.j. Each resident shall have the following in the bedroom:

- 7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident 2 does not have access to a source of light that can be turned on/off at bedside.

Plan of Correction

Accept (████) - 04/05/2024)

Lamp immediately provided to Resident #2 by Clinical Coordinator on March 19th 2024 at time of inspection .

.PC staff provided education on 3/25/24 as to need for monitor for light sources readily accessible to residents at bedside either by provided built in light source or external sources (lamp ) if physically accessible.

Audit performed on all PC residents room on 4/3/2024 by Clinical Coordinator to ensure compliance for light source by bedside of all current residents. All rooms currently in compliance with either light source /lamp at bedside .

Rooms will be audited when resident moves in and on any change of furniture location by Clinical Coordinator as documented and placed on Monthly QAPI report . This is to start on 4/1/2024 and first QAPI report will be in May , 2024 .

Director of Personal Care to audit results for compliance .

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

Implemented (████) - 04/16/2024)

103d - Storing Food Off Floor

4. Requirements

2600.

103.d. Food shall be stored off the floor.

Description of Violation

On 3/19/24 at approximately 2:30 pm, there were boxes containing melons, cucumbers, beef, chocolate ice cream and other food items stored on the floor in the walk-in refrigerator and freezer.

Plan of Correction

Accept (████) - 04/05/2024)

Plan:

Education provided to Dining Service staff by director of Dining on \_4/2 and 4/3 2024 to immediately upon delivery place delivered items on storage shelves off the floor. see attached education sheet

Audit by Dining Staff to start on April 5th, 2024( 4 ) times per day to ensure all items are put away in a timely manner that are delivered.

Dining Director to report monthly on QAPI report, to start on May 2024, as to compliance with quickly storing food when delivered off the floor.

PCHA to monitor monthly QAPI report for compliance .

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

Implemented (████) - 04/16/2024)

103f - Refrigerator/Freezer Temps

5. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

There were no thermometers in the 3rd floor freezer and the refrigerators in the dining room and kitchenette on the 5th floor.

Plan of Correction

Accept ( [redacted] ) - 04/05/2024)

Plan:

PC staff are to monitor temps nightly in the refrigerators/freezer on each unit that store resident food in the common area. They have sign off sheets in place for temperatures for both the freezer and the refrigerator on Coopers, Anderson and Goods Run. (They had indicated in an email that the refrigerator on Coopers was missing their thermometer on the night of March 18th and the freezer thermometer was broken).

Staff were provided education to replace missing/broken thermometers in refrigerators /freezers immediately upon discovery. Supply of thermometers will be in each care base for easy access. Nightly temperature checks will be taken and signed off by RA staff as previous assigned and audited weekly for compliance by 3rd shift Clinical Coordinator starting on Monday nights 4/8/2024. See attached audit sheet to ensure all temperatures and thermometers are in place.

. Compliance with thermometers and temperature checks will be reported on monthly QAPI report by Director of Personal Care to start in May , 2024.

New supply of thermometers will be issued by Dining Service Director as needed.

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

Implemented ( [redacted] ) - 04/16/2024)

123c Evacuation Diagrams

6. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 48 residents. However, the emergency evacuation diagram posted near room 511 does not include the location of fire extinguishers.

Plan of Correction

Accept ( [redacted] ) - 04/05/2024)

Plan :

New evacuation diagrams were posted on Goods Runs by Assistant Facility Director on April 1st , 2024 as evidenced by example of diagram and picture of diagram on wall attached. Diagram with fire extinguisher labeled in yellow and exit routes posted in West, East and South hall of Goods Run .

Audit to be done monthly to ensure all diagrams are posted with directions and fire extinguishers clearly labeled.

To be reported on monthly QAPI Report by DOPC starting in May 2024 until can be determined to be in compliance

. see attached audit sheet

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

Implemented ( [redacted] ) - 04/16/2024)

## 132e - Fire Drill Sleeping Hours

## 7. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

## Description of Violation

The last fire drill conducted during sleeping hours was on 8/10/23 at 3:30 am.

## Plan of Correction

Accept ( ) - 04/05/2024)

Plan :

Education provided to the Assistant Director of Facilities as to the need for 2 night fire drills /year (once every 6 months ) by Director of Personal care on March 25th , 2024 . Explanation and education provided as to what constitutes a "hour of sleep drill" .

A fire drill was held on the night of April 3rd at approx. 5am with staff and residents participating. Please see attached fire drill sign off .

Assisted Facilities Director and PCHA will both keep record of 6 month time frame for compliance purposes by posting on Calendar and placing on QAPI report to be started on May , 2024. for compliance that next drill is due prior to October 3rd, 2024 .

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

Implemented ( ) - 04/17/2024)

## 181d -Storing Medication

## 8. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

## Description of Violation

Resident 1 self-administers medications and stores medications in his/her room. On [REDACTED] at approximately [REDACTED] there were several unlocked, unattended medications to include [REDACTED] in Resident 1's bedroom.

## Plan of Correction

Accept ( ) - 04/05/2024)

Resident was immediately educated on need to keep all medications in locked dresser drawer (where the rest of [REDACTED] medications were stored) in [REDACTED] room .

Resident was educated by Clinical Coordinator on March 20th , 2024 and documented by CC on chart .

Order obtained by Clinical Coordinator for Speech Therapy to review/evaluate if resident was able to continue to self administer medications safely and resident was found on 3/27/2024 to meet criteria for self administration and storing and keeping meds secure in room. See attached SLP eval and plan of treatment .

Audit by dayshift Clinical Coordinator /PCHA to be checked weekly to ensure compliance with keeping medication stored to start on April 5th , 2024 and reported monthly on QAPI by PCHA to start on May 2024 for compliance tracking purposes until deemed by QAPI team to no longer need monitored.

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

Implemented ( ) - 04/16/2024)

## 184a - Resident's Meds Labeled

## 9. Requirements

184a - Resident's Meds Labeled (*continued*)

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

**Description of Violation**

*The pharmacy labels on the individualized medication packets for multiple residents of the home, including Residents 2 and 3, do not include the prescribed dosage and instructions for administration.*

**Plan of Correction**

Accept ( [REDACTED] ) - 04/05/2024)

*Plan:*

*Immediate fix was to notify current Pharmacy to determine if they had the capabilities to place the directions on the pillow packs currently being used. Call was placed by RN Staff educator to Hershey Pharmacy on March 20th . Pharmacist( and owner) reported recent technology allowed for the directions for medications to be placed at the end of the roll of meds for each resident.*

*The run dated for March 29th would have the directions at the end of the roll to meet compliance .*

*PCHA requested clarification from Pharmacy that was to start on April 1st for the MH (Plan to switch Pharmacy's was already in the works when we were surveyed) if they had the technology to turn on the directions feature for the "pillow packs".*

*Phoebe Pharmacy confirmed to the PCHA on March 26th , 2024 that the directions for medications would be on the first pill run for MH to start on April 5th as evidenced by medication received for another male resident and scanned in as an example of the directions being present on April 2nd, 2024.*

*All future medications supplied by Phoebe Pharmacy will have directions as well as the other rights to ensure rights and checks can be completely verified prior to administration.*

*Audit to be done weekly and started on April 8th by Clinical Coordinator and documented on monthly QAPI report (first report on May , 2024) as to include all rights information on the pill pack or label .*

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

**Implemented ( [REDACTED] ) 04/16/2024)**