

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

May 13, 2024

[REDACTED], ADMINISTRATOR
WELSH MOUNTAIN HOME INC
[REDACTED]

RE: WELSH MOUNTAIN HOME
567 SPRINGVILLE ROAD
NEW HOLLAND, PA, 17557
LICENSE/COC#: 32172

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/09/2024, 04/10/2024 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: *WELSH MOUNTAIN HOME* License #: *32172* License Expiration: *05/31/2024*
 Address: *567 SPRINGVILLE ROAD, NEW HOLLAND, PA 17557*
 County: *LANCASTER* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *WELSH MOUNTAIN HOME INC*
 Address: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *10/13/2013* Issued By: *Salisbury Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *33* Waking Staff: *25*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Incident* Exit Conference Date: *04/10/2024*

Inspection Dates and Department Representative

04/09/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *52* Residents Served: *33*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *0*

Number of Residents Who:
 Receive Supplemental Security Income: *5* Are 60 Years of Age or Older: *29*
 Diagnosed with Mental Illness: *3* Diagnosed with Intellectual Disability: *12*
 Have Mobility Need: *0* Have Physical Disability: *0*

Inspections / Reviews

04/09/2024 Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/25/2024*

04/22/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *04/30/2024*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *04/30/2024*

Inspections / Reviews *(continued)*

04/30/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 05/07/2024

05/13/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/30/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

102i - Soap Dispenser

1. 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 04/10/2024, at approximately 11:40AM, there was an unlabeled, used bar of soap located on the sink counter in the shared bathroom of Resident Rooms 107 and 109.

Plan of Correction

Accept ([redacted]) - 04/26/2024)

On 4/10/2024 the Director of Wellness removed the bar soap from the sink and placed it in a labeled container. The Director of Wellness then inspected all shared bathrooms for bar soaps and educated residents on the regulation regarding bar soap being kept in a labeled container when not in use. The weekly room/bathroom audit tool has been updated to include that staff will now check that bar soap is in a container, that includes a label, and not open lying on the sink. Please find the attached, modified audit tool that was implemented on 4/15/2024. Starting on 4/22/2024 the Director of Wellness will spot check 50% of shared bathrooms to assure that audits are being done correctly. A record of the weekly audits will be kept. A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation by the administrator. Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented ([redacted]) - 05/13/2024)

105g - Lint Removal and Duct Cleaning

2. 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 4/9/24 at approximately 9:30 am, there was an approximate 1/2-inch accumulation of lint in the lint trap of Dryer #3 in the basement laundry room. There were no clothes in the dryer at the time.

Plan of Correction

Accept ([redacted]) - 04/26/2024)

On 4/10/2024 the Director of Wellness removed any lint from all dryers. The dryer lint audit tool has been updated to check off each individual dryer when emptied instead of one check that all dryers were emptied. Laundry is the responsibility of 3rd shift. On occasion, 1st & 2nd shift will do laundry if clothing or linen is soiled. If 1st & 2nd shift box is empty, no laundry was done on those shifts. The director of wellness will be inspecting dryers randomly but not less than once per week and initialing the audit tool the day she inspects them. These audits will continue indefinitely to assure compliance. Updated audit tool implemented on 4/15/2024. A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. All staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Proposed Overall Completion Date: 05/01/2024

105g - Lint Removal and Duct Cleaning (continued)

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented () - 05/13/2024)

131f - Fire Extinguisher Inspection

3. Requirements

2600.

131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher next to Resident Room #108 on the first floor has not been inspected by a fire safety expert since September 2022.

Plan of Correction

Directed () - 04/26/2024)

On 4/10/2024 the Director of Facilities replaced the out of date fire extinguisher with one that had a 9/2023 inspection date. The Director of Facilities will do an inspection of all fire extinguishers with the completion of each phase of the building renovation, estimated date of completion of all phases is 12/2024. The annual fire extinguisher inspection will not be scheduled unless the facilities director is available to walk with the inspection company's technician, to ensure that all extinguishers have been inspected and received a new tag. Please see the audit tool with list of where all extinguishers are located. This tool will be used with the completion of renovation phases as well as the annual inspection. As our building renovations continue, and fire extinguisher locations may change, the audit tool will be updated. Audit tool is attached and will be updated, as phases of the building renovations are completed.

A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. All Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Directed:

- On 4/10/2024 the Director of Facilities replaced the out of date fire extinguisher with one that had a 9/2023 inspection date.
- BY 5/15/23, The Director of Facilities will perform an initial walk-through to verify that every fire extinguisher in the home is in compliance.
- A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. All Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented.
- Starting 5/1/24, Director of Facilities will perform a monthly walk-through of the building, including areas under renovation, to verify that all fire extinguishers remain compliant. These walk-throughs will be performed until at least 12/2024. Documentation of these walk-throughs and the results will be kept.

Directed Completion Date: 05/01/2024

Implemented () - 05/13/2024)

185a - Implement Storage Procedures

4. Requirements

185a - Implement Storage Procedures (continued)

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] as needed for [redacted] and [redacted] as needed for rash. During the inspection on [redacted], these medications were not available in the home.

Resident #3 is prescribed [redacted] twice daily as needed for itch/rash. During the inspection on 4/10/24, this medication was not available in the home.

Plan of Correction

Accept [redacted] - 04/30/2024)

The Director of Wellness contacted the pharmacy manager, on 4/10/2024, and clarification was obtained that when the pharmacist audits the med-box, they are only checking for expired medications and to make sure that medications and treatments are not being stored together. This was a miscommunication as our facility thought the pharmacy was checking medications and orders.

The med-box audit tool has been updated to include that all meds in the med-box have an order on the eMAR system and that all medications are available if an order appears on the eMAR system. Please find the updated med-box audit tool that was implemented on 4/15/2024. Weekly med box audits will continue indefinitely, and the Director of Wellness will spot check 50% of med boxes monthly to ensure compliance.

A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation by the administrator. Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented [redacted] - 05/13/2024)

187a - Medication Record

5. Requirements

2600.

187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident's name.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

187a - Medication Record (continued)

Description of Violation

Resident #2 is prescribed [redacted] one tablet as needed for nausea. However, Resident #2's medication administration record for March 2024 does not include the prescribed medication.

Resident #4 is prescribed [redacted] and [redacted]. However, the resident's medication administration record for April 2024 does not indicate the diagnosis or purpose for these medications.

Plan of Correction

Accept [redacted] - 04/30/2024)

Res #2: The order for [redacted] was discontinued on [redacted]. This order was to treat a temporary condition that has resolved.

Res #4: On 4/10/2024, the Director of Wellness audited the eMAR of all residents for diagnoses compliance. It was noted that the pharmacy was sometimes making notes in the diagnoses box such as "family will supply" and the diagnoses would be there, but not visible unless you scrolled through the text. The Director of Wellness notified the pharmacy manager on 4/10/2024 and explained that it is not compliant or acceptable to write notes in the diagnosis box. All text, except for diagnoses, was deleted. All medications now have a diagnosis visible. The med-box audit tool has been updated to include that all meds in the med-box have an order on the eMAR system and that all medications are available if an order appears on the eMAR system. Please find the updated med-box audit tool.

Starting 5/15/24, The Director of Wellness will audit 50% of the census and compare to the weekly audit tool to assure compliance. On 4/10/2024 the Director of Wellness contacted the pharmacy manager and clarification was obtained that when the pharmacist audits the med-box, they are only checking for expired medications and that medication and treatments are not stored together. This was a miscommunication as our facility thought the pharmacy was checking medications and orders. Updated audit tool implemented 4/15/2024 is attached.

A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Proposed Overall Completion Date: 05/01/2024

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented [redacted] - 05/13/2024)

191 - Resident Right to Refuse

6. Requirements

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted on [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction

Accept [redacted] - 04/30/2024)

Resident #1 was notified of their right to refuse medications and treatments by the Director of Resident Services on 4/10/2024. The resident did not offer any complaints or concerns about not being informed prior. On 4/15/2024 the home contract had been amended to include the resident's right to refuse treatments including medications. (Attachment "C" which is the last two pages of the document) The amended agreement was reviewed and

191 - Resident Right to Refuse (continued)

approved by our legal team on 4/17/2024. The version of the contract, that resident #1 received, was newly drafted in February of 2023. On 4/15/2024 the Director of Resident Services audited all admission dates in TabulaPro (Software that retains admission documents) Any resident that was admitted under the new contract was informed of the missing resident right, and given a copy of the amended attachment "C". A copy of Attachment "C" with the resident's signature and date has been attached.

A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented (████) - 05/13/2024)

224a - Preadmission Screen Form

7. Requirements

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #1 was admitted to the home on ██████; however, the resident's preadmission screening form was completed on ██████.

Plan of Correction

Accept (████) - 04/30/2024)

The Administrator met with Director of Wellness and the Director of Resident Services on 4/10/2024. Education on the Prescreen regulation and a plan of prevention was discussed. Whomever does the assessment will place a reminder on the Outlook calendar 25 days after the Pre-Screen Assessment was completed to ensure the resident has been admitted within the 30 day regulation, or a second assessment will be done to assure compliance if the resident had a delay of admission for any reason. An admission day audit tool was created to assure that all documents are completed and compliant on day of admission. Audit tool will be implemented at the next new admission. Please find the attached audit tool.

A staff meeting was held on 4/15/2024 at 1:30pm, where the violation report was reviewed along with the RCG regulations for each violation, by the administrator. Staff was educated on the regulations, how to prevent further violations and the new audit tool was introduced and implemented. The staff meeting was recorded on an iPad for employees who could not attend in person. All staff will have viewed the recorded meeting by 5/1/2024.

Licensee's Proposed Overall Completion Date: 05/01/2024

Implemented (████) 05/13/2024)