pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LANCASTER PCH LLC**
LEGAL ENTITY

To operate **LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER**
NAME OF FACILITY OR AGENCY

Located at **31 MILLERSVILLE ROAD, LANCASTER, PA 17603**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **100**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 40**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 9, 2024** until **July 9, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333060**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: JULY 9, 2024

Lancaster PCH LLC

: Legend Personal Care and Memory Care of Lancaster
31 Millersville Road,
Lancaster, Pennsylvania 17603
License #: 33306

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on July 3, 2024, of the above facility, we have determined that your submitted plan of correction is fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-Term Living

Enclosure
<Licensing Inspection Summaries>

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17105 | 717.783.3670 | F 717.783.5662 | www.dpw.pa.gov

Department of Human Services

Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

July 3, 2024

LANCASTER PCH LLC

RE: LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER
31 MILLERSVILLE ROAD
LANCASTER, PA, 17603
LICENSE/COC#: 33306

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/09/2024, 04/09/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *06/22/2024*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31* [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *113* **Waking Staff**: *85*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Renewal, Complaint, Incident, Interim* **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: *100* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *40* **Residents Served**: *30*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *80*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

04/09/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/29/2024*

Inspections / Reviews *(continued)*

05/08/2024 - POC Submission

Submitted By:
Date Submitted: *05/10/2024*
Reviewer:
Follow-Up Type: *POC Submission*
Follow-Up Date: *05/14/2024*

05/10/2024 - POC Submission

Submitted By:
Date Submitted: *05/10/2024*
Reviewer:
Follow-Up Type: *Document Submission*
Follow-Up Date: *05/17/2024*

07/03/2024 - Document Submission

Submitted By:
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

There following incidents were not reported to the department by the home:

On [redacted]/25/23, an odor of gas was detected in the home. The fire department was called, and all residents were evacuated. The home did not submit an incident report to the department.

On [redacted]/24, Resident 3 experienced an unwitnessed fall, and was subsequently transported to the emergency room. Resident 3 sustained a head injury from this incident The home did not submit an incident report to the Department.

On [redacted]/24, Resident 6 experienced an unwitnessed fall, and was subsequently transported to the emergency room. Resident 6 sustained a hip fracture from this incident The home did not submit an incident report to the Department.

Repeated Violation- 9/25/23, et al, 8/28/23, et al and 6/6/23, et al

Plan of Correction *Directed ([redacted] - 05/10/2024)*

With Respect to the specific deficiency cited:
The home failed to report the incidents on the above-mentioned dates. The Residence Director is aware of the requirement/regulation however failed to follow procedure/protocol, The failure to file the report was not willful but merely an oversight.
With Respect to Systemic Measures that have been put into place to address the stated concern:
Reporting incidents allows the Department to respond promptly to serious situations.
The Regional Director of Operations, trained the identified reporters on 4/11/24 regarding Regulation 2600.16, Reportable Incidents and Conditions. Immediately, to prevent this from happening again the Residence Director and/or designee will file reports timely in alignment with the regulatory requirement and a copy of the incident will be retained on record. The home's Administrator/Designee will remain available daily to submit reportable incidents to the department within 24 hours of the incident.
An audit of reportable incidents was conducted on 4/12/24 with no other reporting issues discovered.
To avoid future violations of this nature effective immediately 04.11.2024, all reportable incidents will be completed and/or reviewed by the Residence Director within 24 hours daily to ensure accurate resident information is captured and reported appropriately and timely.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.16c, Written Incident Report Abuse Reporting Covered by Law, will be
conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.
On [redacted]/24, Resident 3 experienced an unwitnessed fall, and was subsequently transported to the

16c - Written Incident Report (continued)

emergency room. Resident 3 sustained a head injury from this incident the home did not submit an incident report to the Department.
I would like to respectfully request that this is rescinded from the VR since the responsibility of the home was appropriate and timely.
Resident #3 did have an incident on /24 and the report was filed via e-mail on 3/13/24 timely. There is a copy of that report e-mail transaction accordingly and a copy is on the resident chart accordingly. A copy of that report will be provided as a supporting document.
With Respect to the specific deficiency cited:
In the event the violation remains in place: The home failed to report the incidents on the above-mentioned dates. The Residence Director is aware of the requirement/regulation however failed to follow procedure/protocol.
With Respect to Systemic Measures that have been put into place to address the stated concern:
Reporting incidents allows the Department to respond promptly to serious situations.
The Regional Director of Operations, trained the identified reporters on 4/11/24 regarding Regulation 2600.16, Reportable Incidents and Conditions. Immediately, to prevent this from happening again the Residence Director and/or designee will file reports timely in alignment with the regulatory requirement and a copy of the incident will be retained on record. The home's Administrator/Designee will remain available daily to submit reportable incidents to the department within 24 hours of the incident.
An audit of reportable incidents was conducted on 4/12/24 with no other reporting issues discovered.
To avoid future violations of this nature effective immediately 04.11.2024, all reportable incidents will be completed and/or reviewed by the Residence Director within 24 hours daily to ensure accurate resident information is captured and reported appropriately and timely.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.16c, Written Incident Report Abuse Reporting Covered by Law, will be
conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.
On /24, Resident 6 experienced an unwitnessed fall, and was subsequently transported to the emergency room. Resident 6 sustained a hip fracture from this incident The home did not submit an incident report to the Department.
Resident #6 did not have an incident on .2024 which was clarified with BHSL. The verbal conversation at time of inspection did indicate the incident was regarding Resident #1 and not Resident #6. In this occurrence there was a reportable incident filed by the Healthcare Director; However; the reportable document contained an error and listed the resident name incorrectly.
After consultation with the licensing office, the completion of the revised reportable incident form with the corrected information has been updated and faxed on 04.30.2024 to the licensing office with a note on the fax cover sheet explaining the revision. The new incident is now inclusive of the correct resident name and emergency contact information and is on file on the resident chart. Resident #1 no longer resides at the Personal Care Home.
With Respect to the specific deficiency cited:
The home failed to report the incidents on the above-mentioned dates. The Residence Director is aware of the requirement/regulation however failed to follow procedure/protocol.
With Respect to Systemic Measures that have been put into place to address the stated concern:
Reporting incidents allows the Department to respond promptly to serious situations.
The Regional Director of Operations, trained the identified reporters on 4/11/24 regarding Regulation 2600.16, Reportable Incidents and Conditions. Immediately, to prevent this from happening

16c - Written Incident Report (continued)

again the Residence Director and/or designee will file reports timely in alignment with the regulatory requirement and a copy of the incident will be retained on record. The home's Administrator/Designee will remain available daily to submit reportable incidents to the department within 24 hours of the incident. An audit of reportable incidents was conducted on 4/12/24 with no other reporting issues discovered. To avoid future violations of this nature effective immediately 04.11.2024, all reportable incidents will be completed and/or reviewed by the Residence Director within 24 hours daily to ensure accurate resident information is captured and reported appropriately and timely.
With Respect to How the Plan of Corrective Measures will be Monitored:
Compliance monitoring on Regulation 2600.16c, Written Incident Report Abuse Reporting Covered by Law, will be
conducted x 2 quarters as part of Quality Assurance meetings. All records will be retained.

Proposed Overall Completion Date: 05/09/2024

[Directed]
- The administrator or designee will send in an incident report to the Department regarding the incident on 12/25/23 by 5/17/24.

Directed Completion Date: *05/17/2024*

Implemented ██ - 07/03/2024)

107c - Food/Water 3 Day Supply

2. Requirements

2600.
107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 4/9/24, the home served 78 residents. However, the home did not have enough emergency food to sustain 78 residents for 3 days. Also, most of the emergency food supply consisted of things such as canned pudding, canned fruit, canned spaghetti sauce and canned ketchup.

Plan of Correction *Accept (AC - 05/10/2024)*

The Residence Director and Culinary Services Coordinator/Chef failed to maintain and adequate supply of non-perishable food to sustain the population in compliance with Legend standards and regulatory guidelines to support emergency preparedness.

As an educational step On April 9th, 2024 The Divisional Vice President of Legend Senior Living had provided the emergency menu and ordering guidelines and information to all Chefs/Culinary Service Coordinators and Residence Directors. On April 10th, 2024 The Chef/Culinary Services Coordinator did place an order with U S Foods and the order was received on 04/12/2024 and is stored on site. (There are 2 pages of the invoice and three photo's to provide as supporting documents/verification.)

The storage location of the emergency preparedness food is maintained exclusive from any other inventory.

107c - Food/Water 3 Day Supply (continued)

The primary benefit is to ensures adequate food supplies in the event of an emergency. To prevent further non-compliance, effective 05.01.2024 the Culinary Services Coordinator/Chef and/or Residence Director will conduct a monthly inventory audit for the remainder of 2024 utilizing the "Legend Shopping Guide Inventory checklist" and immediately re-order any emergency supply items needed to fulfill a complete ongoing inventory. A review the inventory report will be inclusive in the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented (█ - 07/03/2024)

132a - Monthly Fire Drill

3. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of 2/2024.

Repeated Violation - 6/6/23, et al

Plan of Correction *Accept (█ - 05/10/2024)*

The violation occurred as a result of the Maintenance Director's failure to follow regulatory requirements. The fire system maintenance and monitoring central station company had performed routine testing of the devices and system on 02.22.2024 and verified full compliance of all fire devices However; the Maintenance Director did not perform a drill. The Maintenance Director did complete two separate fire drills in March, assuming (in error) that this would count for the missed drill in February.
The Maintenance Director did receive training with the Residence Director on 04.12.2024 regarding the full regulatory compliance procedure and importance of conducting drills monthly. A record of this training is and will remain on record in the Maintenance Director's training file. In addition, the Maintenance Director is scheduled to attend a Fire Safety Expert training course on May 8th, 2024 with Fire Life Safety Solutions instructor Robert Mueller.
Fire Safety and Emergency Response Train the Trainer Course Description: This program is based on best practices for providing fire safety training for adult learners and uses various instructional techniques along with tips for presenting the included fire safety program to staff members. Lessons learned and common problems associated with teaching adults will also be discussed. This program will provide the participant with the knowledge and skills needed to conduct fire safety training in accordance with the appropriate regulations and meet the requirements of 55 Code 2600.65 and 55 Code 2800.65 which requires that annual fire safety training be completed by a fire safety expert or by a staff person trained by a fire safety expert. and a record of this training will also be made part of the Maintenance Director's file.
To prevent future occurrences the Maintenance Director will complete monthly fire drills starting 04/12/2024 accordance with the regulation and provide that documentation to the Residence Director for review and recording of each drill. A review of completed fire drills will be inclusive in the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

132a - Monthly Fire Drill *(continued)*

Implemented █ 07/03/2024)

132c - Fire Drill Records

4. 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 drill conducted on 12/30/23, 3/20/24 and 4/4/24 does not include the seconds.

Plan of Correction ***Accept █ - 05/10/2024)***

The violation occurred as a result of the Maintenance Director's failure to follow regulatory requirements. The Maintenance Director did receive training of the regulation by the Administrator/Residence Director on 04.12.2024 and the importance of conducting drills monthly as well as capturing the necessary data to complete a record of the drill. A record of this education is on file in the Maintenance Director's training file. In addition, the Maintenance Director is scheduled to attend a Fire Safety Expert training course on May 8th, 2024 with Fire Life Safety Solutions instructor Robert Mueller.
To prevent future occurrence, effective immediately 04/12/2024-Roy E. Maintenance Director will complete monthly fire drills in accordance with the regulation and provide that documentation to the Residence Director for review and recording of each drill. A review of completed fire drills will be inclusive in the Quality Management Team (comprised of at least the Administrator, Maintenance Director, Chef, Life Enrichment Director, Healthcare Director) review and part of the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented █ - 07/03/2024)

132e - Fire Drill Sleeping Hours

5. 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 4/4/24 at 5:15 am. The previous sleeping hours fire drill was conducted on 6/27/23 at 6:30 am.

Repeated Violation - 6/6/23, et al

Plan of Correction ***Accept █ - 05/10/2024)***

The primary benefit of this regulation is to practice response and evacuation while residents are asleep, since an
individual's response time and actions when waking from sleep are reduced. As a result of the home conducting a self-audit on 04.03.2024 and upon realizing the night time drill was past due, both the Residence Director and Maintenance Director did conduct a night time drill on 04.04.2024 at 5:15 a.m. as

132e - Fire Drill Sleeping Hours (continued)

noted.
The violation occurred as a result of the Maintenance Director's failure to follow regulatory requirements. The Maintenance Director did receive training by the Administrator/Residence Director on 04.12.2024 regarding the full regulatory compliance procedure and importance of conducting drills monthly as well as capturing the necessary data to complete a record of the drill. A record of this training is and will remain on record in the Maintenance Director's training file. In addition, the Maintenance Director is scheduled to attend a Fire Safety Expert training course on May 8th, 2024 with Fire Life Safety Solutions instructor Robert Mueller.
To prevent future occurrences the Maintenance Director will effective 04/24/2024 begin conducting monthly fire drills in accordance with the regulation to include required night time fire drills. The Maintenance Director will provide that documentation to the Residence Director for review and recording of each drill. A review of completed fire drills will be inclusive in the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented - 07/03/2024)

132g - Fire Drills Days/Times

6. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills between 11:00 am and 5:26 pm as evidenced by the following drills:
8/27/23 at 3:50 pm
9/26/23 at 2:18 pm
10/25/23 at 3:00 pm
11/16/23 at 2:00 pm
12/30/23 at 5:26 pm
1/30/24 at 3:15 pm
2/22/24 at 1:15 pm
3/15/24 at 11:00 am
3/20/24 at 11:30 am

.

Plan of Correction *Accept - 05/10/2024)*

The violation occurred as a result of the Maintenance Director's failure to follow the homes outlined fire drill cadence and regulatory requirements. The Maintenance Director, did receive training by the

132g - Fire Drills Days/Times (continued)

Administrator/Residence Director on 04.12.2024 regarding the full regulatory compliance procedure and importance of conducting drills on different days of the week each month alternating between the three shifts. A record of this training is and will remain on file in the Maintenance Director's file. In addition, the Maintenance Director is scheduled to attend a Fire Safety Expert training course on May 8th, 2024 with Fire Life Safety Solutions instructor [redacted].
To prevent future occurrences [redacted] Maintenance Director effective 04/24/2024 will conduct monthly fire drills in accordance with the regulation to include varying dates/times/days/shifts/exits used for each fire drill. The Maintenance Director will provide that documentation to the Administrator/Residence Director for review and recording of each drill. A review of completed fire drills will be inclusive in the Quality Management Plan for the remainder of 2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented [redacted] - 07/03/2024)

142a - Secure Medical Care

7. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

Resident 6 has misplaced [redacted] bottom dentures. The home sent a request to resident's provider on 2/20/24 stating the resident had trouble chewing, was missing dentures and in need of treatment and evaluation. However, there was no follow up by the home after this request was made. Resident continues to have difficulty chewing [redacted] food during meals.

Plan of Correction

Accept [redacted] - 05/10/2024)

Resident was out of facility and returned on 12/22/2023. Upon return [redacted] did not have possession of [redacted] bottom dentures and [redacted] aware.
On 02.20.2024 the Healthcare Director reached out to the primary care physician stating the resident had trouble chewing and was missing dentures and in need of treatment.
On 02.22.2024 the PCH did receive an order via fax from the PCP. The physician ordered an evaluation with speech therapy. On this same date the order was provided to Fox Rehabilitation.
Fox Rehab consulted with resident's [redacted]. The POA declined to pursue the evaluation apparently due to the health insurance co-pay expense.
On 04.09.2024 During the visit with licensing the memory care resident was interviewed by the inspector. The Healthcare Director was present in the Reflections/Memory Care dining room as well. During the conversation between the inspector and resident, the resident vocalized to the inspector that [redacted] just swallows [redacted] food due to [redacted] inability to chew without bottom dentures.
On 04.10.2024 the Healthcare Director did reach out to the [redacted] once again to advise of [redacted] [redacted] ongoing difficulty chewing and [redacted] has again declined to secure replacement bottom dentures due to the

142a - Secure Medical Care (continued)

fact that feels cognitive impairment will simply cause to lose them again and the expense of replacing the denture. The PCP was made aware.
The regulation states that "If a resident has a serious medical or dental condition, reasonable efforts shall be
made to obtain consent for treatment from the resident or the resident's designated person". The home did present a concerted effort to obtain a resolution from the resident's designated person. The Healthcare Director and/or Residence Director should have maintained a story line with chart notes indicative of their efforts but failed to do so with consistency.
On 04.17.2024 As a measure to finalize the outcome regarding the resident's bottom denture replacement the resident was seen on site by and a DME was completed. The Healthcare Director received approval to continue providing resident with a regular diet but can provide soft food consistency. The Healthcare Director consulted with the on 04.17.2024 the aware. The residents RASP was updated on 04.17.2024 by the Healthcare Director and remains on file.
To prevent further occurrence the Residence Director did provide training on 04.12.2024 with the Healthcare Director regarding regulation 142. Effective 05.01.2024 the Healthcare Director will complete a weekly report notes review with the Wellness Center staff to ensure any resident medical needs are being met by the home and the Healthcare Director will remain responsible for timely completion of any necessary updates to the DME & RASP and/or resident needs. A copy of the training retained in the Healthcare Directors file.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented - 07/03/2024)

171b4 - Staff Training

8. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
4. At least one staff member transporting or accompanying the residents shall have completed the initial new hire direct care staff person training as specified in § 2600.65 (relating to direct care staff training and orientation).

Description of Violation

On 9/23, Staff Person A independently transported a resident to an appointment. However, Staff Person A does not have a direct care certification.

Plan of Correction *Accept - 05/10/2024)*

The primary benefit of the regulation ensures that residents are able to receive ADL assistance from a qualified individual when being transported. Staff person A has a Department of Motor Vehicle record on file and meets Legend requirements to drive, however she did not possess the required Direct Care Staff Training certification.
On 04.09.2024 Staff person A provided transportation on this one occasion because the usual driver was unexpectedly not available. This particular resident is very high functioning and the Staff person was trying to do the right thing and avoid the resident missing an appointment.
On 04.23.2024 the staff person did complete the Direct Care Staff Training Program. The certificate of

171b4 - Staff Training (continued)

completion will be provided via Sanswrite as a supporting document and the certificate will also remain on record in the associates training file.
Future drivers will be required to obtain Direct Care Staff training prior to/or within the first 40 hours of training and prior to transportation of residents. Effective immediately 04.12/2024, the Administrator/Residence Director will review that all training is completed and the Direct Care Staff Training certificate as well to ensure the Department of Motor Vehicle reports are and will remain on record in the associate training files accordingly.
An audit for all current drivers records for the home was Completed 04.23.2024 by the CSA/Business Office- [redacted] all files are full compliance. Effective immediately 04.12/2024, the Administrator/Residence Director will review that all training is completed and the Direct Care Staff Training certificate as well to ensure the Department of Motor Vehicle reports are and will remain on record in the associate training files accordingly.
Completed 04.23.2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented [redacted] - 07/03/2024)

171c - Home's Vehicle Documents

9. Requirements

2600.
171.c. The home shall maintain current copies of the following documentation for each of the home's vehicles used to transport residents:
1. Vehicle registration.

Description of Violation

The registration for the home's Buick Sedan expired on 2/29/24. The vehicle's new registration was valid on 4/3/24. However, the home utilized this vehicle to transport residents to their appointments in March 2024.

Plan of Correction *Accept [redacted] - 05/10/2024)*

The importance of the regulations is to ensure that the home's vehicles used to regularly transport residents are following Pennsylvania traffic codes.
The Residence Director/Maintenance Director failed to renew the vehicle registration timely.
On 04.03.2024 as part of a self-internal audit, The Residence Director and Maintenance Director noted the vehicle was not re-registered and the vehicle registration was completed on 04.03.2024 by the Administrator/Residence Director and is provided as a supporting document.
As an educational opportunity on 04.12.2024 the Regional Director of Operations did complete a review training with the Administrator/Residence Director of the regulatory requirements to maintain vehicle compliance.
To prevent a re-occurrence on 04.23.2024 the Residence Director has placed a reminder to renew the vehicle registration prior to 04.03.2024 annually, on the Outlook calendar and has sent the same electronic invitation reminder to the Maintenance Director and Customer Service Associate/Business Office. The updated registration has been placed in the vehicle and a copy is on file in the Residence Director's office.
An audit for all current vehicle records for the home was Completed 04.23.2024 by the Administrator/Residence Director and vehicles/records are in full compliance.
Effective immediately 04.12/2024, the Administrator/Residence Director will continue to ensure the Department of Motor Vehicle reports are and will remain on record and in the vehicles accordingly.

171c - Home's Vehicle Documents (continued)

Completed 04.23.2024.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented ██ - 07/03/2024)

187a - Medication Record

10. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident 4 is prescribed routine Lantus Solostar insulin. This medication was administered on 3/19/24 at night; however, the resident's medication administration record (MAR) doesn't include the date and time medication was administered or the initials of the staff who administered the medication.

Resident 5 is prescribed routine Boudreaux butt paste. This cream was administered on 3/26/24 at night; however, the resident's MAR doesn't include the date and time cream was administered or the initials of the staff who administered the cream.

Plan of Correction ***Accept██ - 05/10/2024)***

The violation was incurred because the Medication Technician on duty failed to initial the EMAR for Resident 4 and therefore did not complete the medication administration record on 03.19.2024 in accordance with Legend policy and BHSL regulatory requirements.
The Healthcare Director did confirm with the Med Tech that the resident did, in fact, receive the prescribed medications accordingly. The Healthcare Director was able to make a late entry note of the on-time administration on the EMAR and remains a matter of record on the EMAR and will be provided via Sanswrite as a supporting document.
The violation was the Medication Technician on duty failed to initial the EMAR for Resident 5 and therefore did not
complete the medication administration record on 03.26.2024 in accordance with Legend policy and BHSL regulatory requirements.
The Healthcare Director did confirm with the Med Tech that the resident did, in fact, receive the prescribed medications accordingly. The Assistant Healthcare Director was able to make a late entry note of the on-time administration on the EMAR and remains a matter of record on the EMAR and will be provided via Sanswrite as a supporting document.
To prevent this from happening again, we have advised the Med Tech staff to notify administration in the event of
experiencing technical difficulty with a MAR so the final step of administration in accordance with Legend policy 10-
03-0020P and regulatory compliance are met. Furthermore, A training was conducted and completed on 04.25.2024 for all med tech staff by the Healthcare Director/Assistant Healthcare Director and Residence Director.

187a - Medication Record (continued)

The purpose of the training is to review policies, procedures, interventions and resources and assistance readily
available when providing medication administration.
Beginning on 05/10/2024, The Healthcare Director/Assistant Healthcare Director will complete weekly audits of the MARS to ensure documentation of medication administration aligns with policy and procedures and that the home is following the directions of the prescriber.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented [redacted] - 07/03/2024)

224a - Preadmission Screen Form

11. 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 9 was admitted to the home on [redacted]/24; however, the resident’s preadmission screening form was not completed.

Repeated Violation - 6/6/23, et al

Plan of Correction *Accept [redacted] - 05/10/2024)*

The primary benefit of the preadmission screening is to ensure that the home can safely meet a resident’s needs prior to admission.
The Regional Healthcare Director did complete an assessment of the resident on 01.22.2024. The nine-page assessment did identify the needs of the resident prior to admission however the Healthcare Director and/or Regional Healthcare Director failed to formulate the information on the state specific preadmission form.
Resident #9 was admitted to the home on [redacted].2024 and discharged on [redacted].2024.
Commencing on 4/24/2024 the Healthcare Director was provided a tracking system which includes the dates of pre-screen, DME, and RASP’s for all residents. The tracking system shall be reviewed by the Healthcare Director and/or Administrator at least monthly to ensure timely and complete assessments are completed timely on the proper forms for all residents.
An initial chart audit was conducted on 04.24.2024 by the Healthcare Director. Monthly Chart audits as initiated on 04.24.2024 will be reviewed as part of monthly Quality Assurance meetings, commencing in May 2024 through the remainder of the year and the Administrator will retain the documentation in the QM report.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented [redacted] - 07/03/2024)

225a - Assessment 15 Days

12. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

An initial assessment was not completed for Resident 9, who was admitted to the home on /24.

Plan of Correction *Accept (AC - 10/2024)*

The timely assessment allows homes to create a comprehensive profile of a resident's needs and serves as the basis for the plan to meet those needs.
The Regional Healthcare Director did complete an assessment of the resident on 01.22.2024. The nine-page assessment did identify the needs of the resident however the Healthcare Director and/or Regional Healthcare Director failed to formulate the information on the state RASP form or equivalent form that captures the same information as indicated on the state form.
Resident #9 was admitted to the home on .2024 and discharged on .2024.
Commencing on 4/24/2024 the Healthcare Director was provided a tracking system which includes the dates of pre-screen, DME, and RASP's for all residents. The tracking system shall be reviewed by the Healthcare Director and/or Administrator at least monthly to ensure timely and complete assessments are completed timely on the proper forms for all residents.
An initial chart audit was conducted on 04.24.2024 by the Healthcare Director. Monthly Chart audits as initiated on 04.24.2024 will be reviewed as part of monthly Quality Assurance meetings, commencing in May 2024 through the remainder of the year and the Administrator will retain the documentation in the QM report.
Commencing on 4/24/2024 the Healthcare Director was provided a tracking system which includes the dates of pre-screen, DME, and RASP's for all residents. The tracking system shall be reviewed by the Healthcare Director and/or Residence Director monthly to ensure timely and complete assessments are done and completed on the proper forms for all residents.
Chart audits will be reviewed as part of monthly Quality Assurance meetings, commencing on 05/1/24 through the remainder of the year and the Administrator will retain the documentation in the QM report.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented - 07/03/2024)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident 8's current assessment was completed on 24. However, the resident's previous assessment was completed on /16/23.

Repeated Violation - 9/25/23, et al and 6/6/23, et al

Plan of Correction *Accept - 05/10/2024)*

Follow through as assessments are developed allows the home to create a comprehensive profile of a

225c - Additional Assessment (continued)

resident's needs and serves as the basis for the plan to meet those needs.
The Healthcare Director failed to complete the document timely; However; did complete a new assessment for Resident #8 on 03/2024.
A chart audit was completed by the Health Care Director on 04.24.2024 & 5/2/2024 ensuring each chart had a completed Resident Assessment and Support Plan.
Commencing on 4/24/2024 the Healthcare Director was provided a tracking system which includes the dates of pre-screen, DME, and RASP's for all residents. The tracking system shall be reviewed by the Healthcare Director and/or Administrator at least monthly to ensure timely and complete assessments are completed timely on the proper forms for all residents.
An initial chart audit was conducted on 04.24.2024 by the Healthcare Director. Monthly Chart audits as initiated on 04.24.2024 will be reviewed as part of monthly Quality Assurance meetings, commencing in May 2024 through the remainder of the year and the Administrator will retain the documentation in the QM report.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented - 07/03/2024)

227d - Support Plan Medical/Dental

14. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The current assessment/support plan for Resident 5, dated /2/23, does not address dietary or dental needs.

Repeated Violation - 8/28/23, et al

Plan of Correction *Accept - 05/10/2024)*

The Healthcare Director failed to complete the document inclusive of this information.
Resident #5 RASP was updated on 04.16.2024 via addendum by the Health Care Director to reflect the need for dietary and dental needs and is complete.
A chart audit was completed by the Health Care Director on 04.24.2024 & 5/2/2024 ensuring each chart had a completed Resident Assessment and Support Plan.
The tracking system shall be reviewed by the Healthcare Director and/or Residence Director monthly to ensure timely and complete assessments are done and completed on the proper forms for all residents. At the conclusion of the audits and/or as any changes in the plan of care are indicated the Healthcare Director and/or designee will update the resident assessments/support plans as resident care needs change accordingly.
Monthly Chart audits as initiated by the Healthcare Director on 04.24.2024 and completed on 05.02.2024 will be reviewed as part of monthly Quality Assurance meetings, commencing in May 2024 through the remainder of the year and the Administrator will retain the documentation in the QM report.

227d - Support Plan Medical/Dental *(continued)*

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented █ - 07/03/2024)

231c - Preadmission Screening

15. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident 7 was admitted to the Secure Dementia Care Unit (SDCU) on █23. However, Resident 7's written cognitive preadmission screening was completed on 6/12/23.

Plan of Correction *█ - 05/10/2024)*

The resident was admitted to the home on █.2022 in personal care where she resided until █.2023. There is a DME performed and on record by the PCP dated 06.27.2023 as a status change and SDCU need and the resident transitioned to Reflections Memory Care on 07.03.2023.
The former Healthcare Director failed to complete an updated pre-screen timely to align with the resident transition from personal care to memory care.
An updated pre-screen document was completed on 04.11.2024 by Residence Director/Administrator and the document is on file in the resident chart.
Commencing on 4/11/2024 the Healthcare Director was provided a Resident Record Order form which includes a list of necessary forms for all residents admitted to the home. The form shall be utilized as a tool by the Healthcare Director and/or Residence Director upon each new admission to ensure timely and complete pre-screen's are captured on proper forms for all residents and each of the required forms are present in the resident chart.
Commencing on 05.02.2024 Chart audits will be completed as part of the move in process by the Residence Director on the date of move in. At the conclusion of the audit modifications can be made within the allowable timeframe to align with the resident record and move in date.
A chart audit was completed by the Health Care Director on 04.24.2024 & 5/2/2024 ensuring each chart had a completed Prescreen, Resident Assessment and Support Plan.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented █ - 07/03/2024)

234a - Admission Support Plan

16. 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 7 was admitted to the Secure Dementia Care Unit (SDCU) on █/23. However, the resident's initial support plan was completed on 9/13/23.

234a - Admission Support Plan *(continued)*

Plan of Correction *Accept - 05/10/2024)*

Ensures that there is a plan to serve residents with challenging behaviors as soon as possible and a written plan of care helps both the resident and home to define and establish what kinds of services the resident needs.
The resident was admitted to the home on 09.03.2022 in personal care where she resided until 07.03.2023 and the resident transitioned to Reflections Memory Care on 07.03.2023.
The former Healthcare Director failed to complete an updated RASP timely to align with the resident transition date from personal care to memory care.
The resident was out of the facility on the date of inspection and has since returned as of 05.03.2024 and an updated RASP has been completed by the Healthcare Director and will be retained on file in the resident record.
Commencing on 4/24/2024 the Healthcare Director was provided a tracking system which includes the dates of pre-screen, DME, and RASP's for all residents. The tracking system shall be reviewed by the Healthcare Director and/or Residence Director monthly to ensure timely and complete assessments are done and completed on the proper forms for all residents.
A chart audit was completed by the Health Care Director on 04.24.2024 & 5/2/2024 ensuring each chart had a completed Prescreen, Resident Assessment and Support Plan.
Chart audits will be reviewed as part of monthly Quality Assurance meetings, commencing on 05/1/24 through the remainder of the year and the Administrator will retain the documentation in the QM report.

Licensee's Proposed Overall Completion Date: *05/09/2024*

Implemented - 07/03/2024)

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

July 3, 2024

LANCASTER PCH LLC
31 MILLERSVILLE ROAD
LANCASTER, PA, 17603

RE: LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER
31 MILLERSVILLE ROAD
LANCASTER, PA, 17603
LICENSE/COC#: 33306

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/30/2024, 05/31/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *06/22/2024*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

County: *LANCASTER* **Region**: *CENTRAL*

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/19/2006* **Issued By**: *Manor township*

Type: *I-2* **Date**: *12/19/2006* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *110* **Waking Staff**: *83*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**: *0*

Reason: *Complaint, Incident, Interim* **Exit Conference Date**: *05/31/2024*

Inspection Dates and Department Representative

05/30/2024 - On-Site: [redacted]

05/31/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *77*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *40* **Residents Served**: *27*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *77*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

05/30/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/14/2024*

Inspections / Reviews *(continued)*

06/17/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/02/2024*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *06/21/2024*

06/24/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *07/02/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *07/05/2024*

07/03/2024 - Document Submission

Submitted By: [redacted]
Date Submitted: *07/02/2024*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident 1 is prescribed Potassium Cl ER (10 meq) daily. However, this medication was not administered to the resident from 5/1/24 to 5/7/24 because the medication was not available in the home. The home did not report this incident to the department until 5/8/24.

Repeated Violation - 9/27/23, et al, 8/29/23, et al and 6/6/23, et al

Plan of Correction ***Accept [redacted] - 06/24/2024)***

With Respect to the specific deficiency cited: *The home failed to report the incidents on the above-mentioned dates. The Healthcare Director is aware of the requirement/regulation; however, they failed to follow procedure/protocol; the failure to file the report within the 24-hour time frame was not willful but an oversight. The incident was reported to the Department on 5/8/24 by the Healthcare Director. The re-education has been provided to the Healthcare Director by the Administrator on 6/3/24. This re-education will be retained in the associate file.*

With Respect to Systemic Measures that have been put into place to address the stated: *Any medication errors will be promptly reported within the regulatory guidelines of 24 hours. The Administrator, Healthcare Director, and/or designee will file reports to DHS on time that aligns with the regulatory requirement, and a copy of the incident will be retained in the resident's record. Any necessary re-education will also occur as needed. The current Medication Technicians will be re-educated on promptly reporting medication errors to the Healthcare Director by 6/30/24. Prompt reporting of medication errors will allow the immediate 24-hour reporting timeline and resolution to DHS prompt report process.*

With Respect to How the Plan of Corrective Measures will be Monitored: *Daily monitoring for medication errors will continue by the Healthcare Director/Designee, beginning 6/10/24, so they may be reported timely if there are any additional occurrences. The reporting of incidents will be reviewed in the QMPI meeting each month, beginning 6/20/24, to ensure re-education will occur. All records will be retained in appropriate files.*

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/03/2024)

141a - Medical Evaluation

2. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

Description of Violation

Resident 2's initial medical evaluation is dated [redacted]/23. However, the resident was admitted to the home on [redacted]9/24.

141a - Medical Evaluation *(continued)*

Plan of Correction ***Accept █ - 06/24/2024)***

With Respect to the specific deficiency cited: *the home failed to obtain an updated medical evaluation for resident #2 prior to move-in within the required time frame for DHS compliance.*

With Respect to Systemic Measures that have been put into place to address the stated concern: *The Administrator retrained the Healthcare Director on 6/3/24 regarding Regulation 2600.141a, Medical Evaluations, to prevent this from happening again. The Administrator, Healthcare Director, and/or designee will review all DME's prior to move in and check dates for DHS compliance.*

With Respect to How the Plan of Corrective Measures will be monitored: *Compliance monitoring on Regulation 2600.141.a, will be conducted upon each assessment with the Health Care Director, beginning 6/5/24. The prospected resident and family will be educated on the timeline of the necessary medical evaluation documentation completion required for admission. The Healthcare Director or Administrator shall review all medical evaluations before admission for the accuracy of this regulation timeline. Residents will only be admitted with accurate documentation with the approval of the Healthcare Director and Administrator, who will review the appropriate documentation. These admitting DMEs will be retained in the chart. During the monthly QMPI meeting, the new residents' documents will be reviewed for accuracy each month, beginning 6/20/24.*

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented █ - 07/03/2024)

187d - Follow Prescriber's Orders

4. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 1 is prescribed Potassium Cl ER(10 meq) daily. However, this medication was not administered to the resident from 5/1/24 to 5/7/24 because the medication was not available in the home.

Resident 3 is prescribed isosorbide (40mg) 3x daily. However, this medication was not administered to the resident from 5/23/24 to 5/31/24 because the medication was not available in the home.

Resident 4 is prescribed melatonin (3mg) daily and mesalamine (800 mg) daily. However, the resident's melatonin was not administered to the resident on 5/4/24 due to the medication not being available in the home, and the resident's mesalamine was not administered to the resident from 5/4/24 to 5/13/24 because this medication was not available in the home.

Repeated Violation - 9/27/23, et al, 8/29/23, et al and 6/6/23, et al

Plan of Correction ***Accept █ - 06/24/2024)***

With Respect to the specific deficiency cited: *The home failed to follow the prescriber's orders by not having medication available for the residents listed below.*

187d - Follow Prescriber's Orders (continued)

Resident 1 is prescribed Potassium Cl ER(10 meq) daily. However, this medication was not administered to the resident from 5/1/24 to 5/7/24 because the medication was not available in the home. The medication was re-ordered on 5/8/24.

Resident 3 is prescribed isosorbide (40mg) 3x daily. However, this medication was not administered to the resident from 5/23/24 to 5/31/24 because the medication was not available in the home. The medication was re-ordered on 5/16/24.

Resident 4 is prescribed melatonin (3mg) daily and mesalamine (800 mg) daily. However, the resident's melatonin was not administered to the resident on 5/4/24 due to the medication not being available in the home, and the resident's mesalamine was not administered to the resident from 5/4/24 to 5/13/24 because this medication was not available in the home. The medication was re-ordered on 5/14/24.

With Respect to Systemic Measures that have been put into place to address the stated concern: *The Healthcare Director will provide retraining to current Med Techs on regulation 2600.187.d by 6/30/24, with regard to medication availability, following Physician orders and their responsibility to assure medication is in the medication cart through the pharmacy.*

With Respect to How the Plan of Corrective Measures will be Monitored: *The Healthcare Director and/or designee will audit missed medication daily report in quick MAR summary for 6 weeks to ensure compliance, beginning 6/18/24. These audits will be retained in the POC binder for 6 weeks. Any corrective action will follow if necessary.*

Licensee's Proposed Overall Completion Date: *06/30/2024*

Implemented [redacted] - 07/03/2024)

225a - Assessment 15 Days

5. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 3 was admitted on [redacted]/24; however, the resident's assessment was not completed until 5/28/24.

Plan of Correction ***Accept [redacted] - 06/24/2024)***

With Respect to the specific deficiency cited: *The home failed to complete the assessment for resident 3# in the proper time frame for DHS compliance.*

With Respect to Systemic Measures that have been put into place to address the stated concern: *The*

225a - Assessment 15 Days (continued)

Administrator retrained the Healthcare Director on 6/3/24 regarding Regulation 2600.225a to prevent this from occurring in the future. The Administrator, Healthcare Director, and/or designee will review all assessments for new residents weekly to ensure the assessment is completed promptly on the department-approved document beginning 6/6/24 for accuracy.

With Respect to How the Plan of Corrective Measures will be Monitored: *To ensure consistent adherence to Regulation 2600.225.a, compliance monitoring will be conducted monthly during the QMPI meeting. This regular review, beginning 6/20/24, will be a robust check to ensure this regulation is met. All documents will be retained in the records, further ensuring our commitment to transparency and accountability.*

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented - 07/03/2024)

234a - Admission Support Plan

6. 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 6 was admitted to the Secure Dementia Care Unit (SDCU) on /24. However, the resident's initial support plan was completed on 24.

Plan of Correction ***Accept 06/24/2024)***

With Respect to the specific deficiency cited: *The home failed to complete a support plan for resident #6 in the proper time frame for DHS compliance.*

With Respect to Systemic Measures that have been put into place to address the stated concern: *The Administrator retrained the Healthcare Director on 6/3/2024 regarding Regulation 2600.234a, Support Plans. To prevent this from happening in the future, the Administrator, Healthcare Director, and/or designee will review all assessments for new residents weekly beginning 6/6/2024.*

With Respect to How the Plan of Corrective Measures will be Monitored: *Compliance monitoring on Regulation 2600.234.a will be conducted each month during the QMPI meeting as a review to ensure this regulation is met, beginning 6/20/24. All documents will be retained in the records.*

Licensee's Proposed Overall Completion Date: *06/21/2024*

Implemented - 07/03/2024)