pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **COLUMBIA/WEGMAN SOUTHAMPTON,LLC**
LEGAL ENTITY

To operate **THE PROVINCE OF SOUTHAMPTON**
NAME OF FACILITY OR AGENCY

Located at **1160 STREET ROAD, SOUTHAMPTON, PA 18966**
(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 **106** (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 36**

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 **October 4,** **2024** until **April 4,** **2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **145381**

ISSUING OFFICER

Juliet Marsala
ACTING 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 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: OCTOBER 4, 2024

[redacted]
[redacted]
Columbia/Wegman Southampton LLC
[redacted]
[redacted]

RE: The Province of Southampton
1160 Street Road
Southampton, Pennsylvania 18966
License #: 145381

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection February 26 and 27, 2024, and April 29, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance 145380 dated July 17, 2024 to July 17, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated July 17, 2024 to July 17, 2025 is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from October 4, 2024 to April 4, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

[redacted]

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *THE PROVINCE OF SOUTHAMPTON* **License #**: *14538* **License Expiration**: *07/17/2024*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *09/20/2019* **Issued By**: *Upper Southampton Township*

Type: *I-2* **Date**: *09/20/2019* **Issued By**: *Upper Southampton Township*

Type: *Other* **Date**: *09/20/2019* **Issued By**: *Upper Southampton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *97* **Waking Staff**: *73*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/27/2024*

Inspection Dates and Department Representative

02/26/2024 - On- [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *57*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *36* **Residents Served**: *15*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *57*

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

Have Mobility Need: *40* **Have Physical Disability**: *1*

Inspections / Reviews

02/26/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2024*

04/03/2024 - POC Submission

Submitted By: [redacted]*ri* **Date Submitted**: *03/27/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/06/2024*

04/10/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/05/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/12/2024*

09/10/2024 - Document Submission

Submitted [redacted] **Date Submitted**: *04/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 02/26/24, at 2:34 PM, the medication narcotic count book was unlocked, unattended, and accessible on top of medication cart #2 on the second floor.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: On 02/26/24, at 2:34 PM, the medication narcotic count book was unlocked, unattended, and accessible on top of medication cart #2 on the second floor.
This occurred because Med-Tech failed to store narcotic log in locked med cart when leaving med cart unattended.
Plan of Correction:
• Corrected onsite during inspection. Med tech Immediately placed Narcotic Log Book inside Med Cart on 2/26/2024
• To prevent this from happening again, Health Service Director provided immediate education on 2/26/24 to med tech on cart at time of inspection on appropriate handling of Narcotic Log book.
• Health Care Director completed education for all med techs/Nurses on appropriate handling of Narcotic Log book. Training completed on 3/14/24.
• Effective immediately, The med-techs will ensure the log is securely stored, when not in use, at all times.
• Health Care Director and Assistant Health Care Director will randomly monitor for compliance to prevent reoccurring violation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Not Implemented [redacted] - 05/16/2024)

18 - Compliance With Laws

2. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Carbon Monoxide detector in the kitchen is ten feet from the gas grill.
Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: The Carbon Monoxide detector in the kitchen is ten feet from the gas grill. Per the Care Facility Carbon Monoxide Alarms Standards Act of Jun. 23, 2016; Carbon Monoxide alarms must be installed in proximity of, but not less than 15 feet from any fossil-fuel burning device or appliance.
This occurred because builder may not have been aware of this regulation at time of installation.
Plan of Correction:
• Corrected onsite during inspection. Current CO2 detector is hardwired 10ft away from fossil fuel burning device/kitchen hood. Maintenance Director placed additional battery-operated Carbon Monoxide detector 15ft

18 - Compliance With Laws (continued)

away from fossil fuel burning device/kitchen. (picture attached).
• Maintenance Director will inspect the residence for any other fossil fuel burning devices that would require a carbon monoxide detector to ensure to is in place and not less than 15 feet form the device or appliance.
• Residence Director educated Maintenance Director on 3/4/2024, regarding regulation and maintaining operation of battery operated CO2 detector and use TELS to track operation and battery replacement date.
• Maintenance Director and /or Residence Director will complete TELs task every 6 months as required in TELS

Proposed Overall Completion Date: 03/28/2024

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/16/2024)

25a - Written Contract and Review

3. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #1 was admitted to the home on [redacted] The resident's contract was signed by resident #1's legal representative [redacted] 24. Resident #1 did not sign or review the contract until 02/21/24.

Plan of Correction ***Accept[redacted] - 04/03/2024)***

Description of Violation: Resident #1 was admitted to the home on [redacted] /24. The resident's contract was signed by resident #1's legal representative on 01/20/24. Resident #1 did not sign or review the contract until 02/21/24
This occurred because prior Residence Director failed to secure signature prior to or within 24 hours of admission.
Plan of Correction:
• Residence Director will review resident contract with resident prior to or within 24 hours of a new admission and obtain resident signature to prevent further reoccurrence of violation.
• Residence Director educated Customer Service Assistant on the regulation and utilizing the community's business file checklist completed on 3/13/2024.
• The RD and/or Customer service Assistant will audit all current resident business files to ensure that the agreements were reviewed at the time of move in by 4/15/2024.
• Effective immediately, Customer Service Assistant and/or Residence Director will audit residents' business file upon move in for compliance with regulation utilizing resident business file audit tool to prevent further reoccurrence of violation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/16/2024)

25b - Contract Signatures

4. Requirements

2600.

25b - Contract Signatures *(continued)*

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted]23, for resident #2 was not signed by the resident.

Plan of Correction ***Accept[redacted] - 04/03/2024)***

Description of Violation The resident-home contract, dated 0[redacted]23, for resident #2 was not signed by the resident. This occurred because prior Residence Director failed to obtain resident signature in addition to legal representative signature on resident-home contract.

Plan of Correction:

• The Residence Director reviewed the resident contract with resident and obtained signature on 3/15/24.

• The Residence Director will review resident-home contract with new residents prior to or within 24 hours of a new admission and obtain resident signature.

• Residence Director educated Customer Service Assistant on the regulation and utilizing the resident business file audit tool on 3/13/2024.

• The RD and/or Customer Service Assistant will audit all current resident business files to ensure that the agreements were signed at the time of move in by 4/15/2024.

• Customer Service Assistant and/or Residence Director will audit resident's business file upon move in for compliance with regulation and ensure proper signature upon move in.

Proposed Overall Completion Date: 03/28/2024

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented[redacted] - 05/16/2024)

26c - QM Improvement

5. Requirements

2600.

26.c. The quality management plan shall include the development and implementation of measures to address the areas needing improvement that are identified during the periodic review and evaluation.

Description of Violation

The home's quality management minutes, dated [redacted]/24, do not include development and implementation of measures to address:

- *Reportable and Non-Reportable Incidents,*
- *Complaints, suggestions and concerns of the residents, families, associates and vendors,*
- *Regulatory issues, plans of corrections, changes and survey readiness,*
- *Resident Council meeting minutes,*

as described in the home's Quality Management Program procedures (02-02-0010P) of the Administration Policy Manual with an effective date of 12/01/2012 and a revised date of 03/07/2019.

Plan of Correction ***[redacted] 04/03/2024)***

Description of Violation: The home's quality management minutes, dated 01/10/24, do not include development and implementation of measures to address: Reportable and Non-Reportable Incidents, Complaints, suggestions and concerns of the residents, families, associates and vendors, Regulatory issues, plans of corrections, changes and survey readiness, Resident Council meeting minutes, as described in the home's Quality Management Program

26c - QM Improvement (continued)

procedures (02-02-0010P) of the Administration Policy
This occurred because prior Residence Director failed to provide training on proper procedures on conducting Quality Management meeting prior to appointing responsibility to another member of management.
Plan of Correction:
• Effective immediately, the Residence Director will add, Reportable and Non-Reportable Incidents, Complaints, suggestions and concerns of the residents, families, associates and vendors, Regulatory issues, plans of corrections, changes and survey readiness, Resident Council meeting minutes to the QMP to ensure these topics are covered as required by the regulation.
• The Residence Director provided Education to Maintenance Director, Health Care Director and Assistant Health Care Director on regulation and utilizing community agenda for QM meetings. Training completed on 3/15/2024.
• New Residence Director and/or designee to attend and/or conduct final review of documentation from QM meeting to ensure it meets required topics per policy and regulation in effort to avoid reoccurrence of violation. To be completed on 3/28/24 at next QM Meeting.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/16/2024)

28e - Death of a Resident

6. Requirements

2600.
28.e. In the event of a death of a resident under 60 years of age, the administrator shall refund the remainder of previously paid charges to the resident's estate within 30 days from the date the room is cleared of the resident's personal property. In the event of a death of a resident 60 years of age and older, the home shall provide a refund in accordance with the Elder Care Payment Restitution Act (35 P. S. § § 10226.101—10226.107). The home shall keep documentation of the refund in the resident's record.

Description of Violation

Resident #3 passed away on [redacted]23. Resident #3's personal belongings were removed from their room on 10/04/23; however, the resident's refund was not issued until 11/07/23.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: Resident #3 passed away on [redacted]23. Resident #3's personal belongings were removed from their room on 10/04/23; however, the resident's refund was not issued until 11/07/23.
This occurred because Customer Service Assistant responsible for resident refunds was new to the role & was not aware of time frame in which refunds needed to be issued per regulation.
Plan of Correction:
• The residence Director provided education on regulation to Customer Service Assistant who is responsible for move-out process and submitting check request timely to home office for refunds. Education Completed 3/13/2024.
• Customer Service Assistant will follow the Residences' move out process to ensure all refunds are processed and issued within the 30 days, per regulation.
• Effective immediately and ongoing, the Residence Director will review all check requests to verify all refund request were submitted and processed timely.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

41e - Signed Statement

7. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: Resident #2's record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.
This occurred because prior Residence Director failed to obtain resident signature in addition to legal representative signature on resident-home contract.
Plan of Correction:
• The Residence Director reviewed Resident Rights and Complaint procedures outlined in resident's contract and signature was obtained by resident # 2 on 3/15/24.
• New Residence Director will review resident-home contract that includes the Resident Rights and complaint procedures with all new residents prior to or within 24 hours of a new admission and obtain resident signature.
• Residence Director educated Customer Service Assistant on the regulation and utilizing the resident business file audit tool on 3/13/2024.
• The RD and/or Customer Service Assistant will audit all current resident business files to ensure that the agreements were signed at the time of move in by 4/15/2024.
• Customer Service Assistant and/or Residence Director will audit resident's business file upon move in for compliance with regulation and ensure proper signature upon move in.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

42s - [redacted]

[redacted]

42s - [redacted]

[redacted]

[redacted])

65f - Training Topics

9. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident during training year 2023.

Direct care staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident during training year 2023.

Plan of Correction ***Accept ([redacted] - 04/03/2024)***

Description of Violation: Direct care staff person A and staff person B did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, personal care service needs of the resident during training year 2023.

This occurred because prior Residence Director failed to ensure that training topics covered in new hire were covered and ensuring yearly training for 2023 was complete.

Plan of Correction:

• Homes 2024 annual training plan has been reviewed by Residence Director and confirmed it includes the topics outlined in regulation 65f.

• Residence Director has had missing training topics from 2023 reassigned for staff person A and Staff person B to

65f - Training Topics (continued)

completed by 4/15/2024 to ensure completion for 2024 training plan year.

• Residence Director educated Customer Service Assistant on the process of pulling training transcripts from Relias Learning Center monthly to ensure timely completion of annual training. Training completed on 3/13/2024.

• Residence Director and/or Customer Services Assistant to monitor staff completion of monthly scheduled training on the Relias learning platform to ensure timely completion of each training and to prevent further reoccurrence of violation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

65g - Annual Training Content

10. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in resident rights during training year 2023.

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, resident rights during training year 2023.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation :

Staff person A did not receive training in resident rights during training year 2023.

Staff person B did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, resident rights during training year 2023.

This occurred because prior Residence Director failed to ensure that training topics covered ion new hire were covered and ensuring yearly training for 2023 was complete.

Plan of Correction

• Staff person A & B along with current staff received training by Residence Director and Health Services Director on resident rights. Initiated on 3/14/2024 and completed for all staff on 3/24/24.

• Fire Safety training by fire safety expert has ben scheduled with Bob Mueller to satisfy training for Staff person B and current staff. To be completed by 4/1/2024

• Maintenance Director and Residence Director is scheduled to attend the Train the Trainer Fire Safety certification class on 4/10/2024.

• Residence Director and or Maintenance Director upon certification by fire safety expert on 4/10/24 will perform

65g - Annual Training Content (continued)

annual fire safety training with all staff.

• Residence Director and/or Customer Services Assistant to monitor staff completion of monthly scheduled training on the Relias learning platform to ensure timely completion of each training and to prevent further reoccurrence of violation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

81b - Resident Personal Equipment

11. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #5 has a bedside mobility device on their bed. The device has a cover but leaves an opening measuring 11 inches by 8 inches. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place.". The device is not securely attached to the bed, the device is partially slid under the mattress but is sticking out at the top. The enabler strap is on the floor. The manufacturer's instructions are not being followed.

Resident #6 has a bedside mobility device that is not attached to the bed and is easily moved. Bedside Mobility Devices must be installed and maintained according to the manufacturer's instructions and be clean, in good repair, and free of hazards.

Plan of Correction ***Accept ([redacted] 04/03/2024)***

Description of Violation
Resident #5 has a bedside mobility device on their bed. The device has a cover but leaves an opening measuring 11 inches by 8 inches. This does not adhere to the FDA guidelines which states "If any openings within the device exceed 120 mm (4 3/4 inches), a cover that allows for safe gripping and use of the device for its intended purpose must be in place.". The device is not securely attached to the bed, the device is partially slid under the mattress but is sticking out at the top. The enabler strap is on the floor. The manufacturer's instructions are not being followed.
Resident #6 has a bedside mobility device that is not attached to the bed and is easily moved. Bedside Mobility Devices must be installed and maintained according to the manufacturer's instructions and be clean, in good repair, and free of hazards
Violation occurred because Health Care Director, Assistant Health Care Director and prior Residence Director did not enforce regulation regarding bedside mobility devices.
Plan of Correction
• Corrected onsite at time of inspection, Health Care Director removed Bedside mobility device from Resident #5's bed on 2/27/24 and resident has subsequently relocated to Florida on 2/29/2024 and is no longer residing in community.
• Corrected onsite at time of inspection, Health Care Director removed Resident # 6 bedside mobility device on 2/27/24 as it has been determined the enable device is no longer needed.
(attached nursing note/RASP addendum)
• The Residence Director educated Maintenance Director, Health Care Director and Assistant Health Care Director on the new guidelines to the use of bedside mobility devices on 3/14/24.

81b - Resident Personal Equipment (continued)

• To prevent further occurrence., The Residence Director sent out notification to families/residents on 3/25/24, regarding the use of bedside mobility devices and to inform the Health Care Director if resident is in need of a bedside mobility device so that we can maintain compliance with regulation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

85d - Trash Receptacles

12. 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 02/26/24, at 9:51 AM, there was an uncovered, unattended trash can in the kitchen. Trash and garbage were in the trash can.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: On 02/26/24, at 9:51 AM, there was an uncovered, unattended trash can in the kitchen. Trash and garbage were in the trash can
Violation occurred because kitchen staff did not replace lids after breakfast service.
Plan of Correction
• Corrected On site during inspection, Residence Director placed lid on trash receptable in kitchen.
• Residence Director educated Staff on Regulation that all trash receptables not in service and unattended must contain a lid. Staff Education completed on 3/4/2024
• To prevent future occurrence, culinary director and or designee will monitor for ongoing compliance to ensure trash cans have lids when not in service utilizing Dining Services Quality Assurance Checklist. Checklist initiated on 3/4/2024

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

89a - Water Pressure

13. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

On 02/26/24, at 12:49 PM, the home did not have sufficient hot water in the first-floor public bathrooms. The water temperature was measured at 53.7 degrees Fahrenheit.

On 02/27/24, at 9:47 AM, the home did not have sufficient hot water in the 2nd floor spa bathroom (266). The water temperature was measured at 72.5 degrees Fahrenheit.

89a - Water Pressure *(continued)*

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: On 02/26/24, at 12:49 PM, the home did not have sufficient hot water in the first-floor public bathrooms. The water temperature was measured at 53.7 degrees Fahrenheit. On 02/27/24, at 9:47 AM, the home did not have sufficient hot water in the 2nd floor spa bathroom (266). The water temperature was measured at 72.5 degrees Fahrenheit

Incident occurred due to Maintenance director not knowing the appropriates water pressure/water temperatures to be maintained per regulation.

Plan of Correction

• Corrected on Site at time of inspection. Maintenance Director removed Pressure Restrictor valves from faucets in first floor and second floor bathrooms to increase water pressure and improve temperature to meet regulatory compliance.

• Residence Director educated Maintenance Director on regulation pertaining to appropriate water temperature to be in compliance with regulation. Training completed on 3/14/2024

• To prevent future occurrences, Maintenance Director and or designee will monitor water temperatures/pressure utilizing the TELS maintenance tracking software, weekly water temperature checks ensure they remain in compliance with water temperature per regulation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

96a - First Aid Kit

14. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the Med Room does not include eye coverings.

Repeat Violation: 4/24/2023 et al.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: The first aid kit in the Med Room does not include eye coverings

Incident occurred because the home did not refer to the required regulatory list of items to be maintained in the first aid kits.

Plan of Correction

• Corrected on Site at time of inspection, Maintenance Director placed eye coverings in med room first aid kit.

• Residence Director educated Maintenance Director /Health Care Director/Assistant Health Care Director on the List of items to be contained in first aid kits on 3/15/2024

• To prevent reoccurrence of violation, Maintenance Director /Health Care Director/Assistant Health Care Director will perform monthly checks on First Aid Kits, for three months, beginning 4/1/2024.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

101j2 - [redacted]

[redacted]

101j3 - [redacted]

[redacted]

101j3 - Bed/Linens/Pillows/Blankets *(continued)*

Implemented [redacted] - 05/17/2024)

102h - Toilet Paper

17. Requirements

2600.
102.h. Toilet paper shall be provided for every toilet.

Description of Violation

On 02/27/24, at 9:47, there was no toilet paper for the toilet in the second-floor spa bathroom (266).

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: On 02/27/24, at 9:47, there was no toilet paper for the toilet in the second-floor spa bathroom (266).
Incident occurred because housekeeping failed to supply second floor spa room with extra toilet paper.
Plan of Correction
• Corrected onsite during inspection, Maintenance Director placed toilet paper in second floor spa bathroom.
• Residence Director educated staff as to the regulation and location of storage for Toilet Paper. Education completed on 3/14/2024
• Maintenance Director will or designee will perform weekly checks for one month on Spa Rooms/restrooms to ensure housekeeping are suppling additional rolls so residents have access to toilet paper per regulation.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

103g - [redacted]

[redacted]

103g - [redacted]

[redacted]

103i - Outdated Food

19. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 02/26/24, at 9:53 AM, the following items were found in the kitchen:

- *a dented can in the dry goods storage area.*
- *an unlabeled, undated unknown type of meat in the refrigerator,*
- *unlabeled, undated food found in the freezer; pie dough, pie crust, unidentified meat in bin, unidentified meat wrapped in plastic wrap.*

Plan of Correction [redacted] ***- 04/03/2024)***

Description of Violation: On 02/26/24, at 9:53 AM, the following items were found in the kitchen: a dented can in the dry goods storage area. an unlabeled, undated unknown type of meat in the refrigerator, unlabeled, undated food found in the freezer; pie dough, pie crust, unidentified meat in bin, unidentified meat wrapped in plastic wrap. Incident occurred due to cooks not properly securing food according to regulation regarding proper food storage.
Plan of Correction
• Corrected onsite during inspection. Cook disposed of dented can. Area in dry storage was marked for placement of dented cans with appropriate signage and notice to do not use.
• Unlabeled and undated items in refrigerator/freezer were disposed of by cook on 2/26/2024 Reminder sign posted along with guidelines outlined in Regulation for food safety and storage on 3/12/2024.
• Residence Director educated kitchen staff on regulation on 3/12/24.
• Culinary director and or designee will perform routing checks beginning 3/4/2024

Licensee's Proposed Overall Completion Date: *03/28/2024*

Not Implemente [redacted] ***- 05/17/2024)***

107a - Emergency Preparedness

20. Requirements

2600.
107.a. The administrator shall have a copy and be familiar with the emergency preparedness plan for the municipality in which the home is located.

Description of Violation

Staff person C, the [redacted] *does not have the emergency preparedness plan for the local municipality.*

107a - Emergency Preparedness *(continued)*

Plan of Correction ***Accept[redacted] - 04/03/2024)***

Description of Violation: Staff person C, the administrator does not have the emergency preparedness plan for the local municipality.

Violation occurred due to prior Administrator not have the local municipalities emergency preparedness plan.

Plan of Correction

• Residence Director obtained copy of the emergency preparedness plan for the municipality in which the home is located and placed it in the home's emergency preparedness binder on 3/19/2024.

• Residence Director will update Emergency preparedness binder as changes occur.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented[redacted] 05/17/2024)

107b - Emergency Procedures

21. Requirements

2600.

107.b. The home shall have written emergency procedures that include the following:

1. Contact information for each resident's designated person.
2. The home's plan to provide the emergency medical information for each resident that ensures confidentiality.
3. Contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.
4. Means of transportation in the event that relocation is required.
5. Duties and responsibilities of staff persons during evacuation, transportation and at the emergency location. These duties and responsibilities shall be specific to each resident's emergency needs.
6. Alternate means of meeting resident needs in the event of a utility outage.

Description of Violation

The home's written emergency procedures do not include contact information for each resident's designated person., contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

Plan of Correction ***Accept[redacted] - 04/03/2024)***

Description of Violation: The home's written emergency procedures do not include contact information for each resident's designated person., contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents.

Violation occurred because prior Residence Director failed to update homes Emergency Preparedness plan to include information outlined per regulation.

Plan of Correction

• Residence Director will update the Home Emergency Preparedness plan to include contact information for each resident's designated person., contact telephone numbers of local and State emergency management agencies and local resources for housing and emergency care of residents by 4/15/2024.

• Ongoing the Residence Director will update Emergency preparedness binder as needed.

• Ongoing the Residence Director will review the Emergency Procedures annually.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented[redacted] - 05/17/2024)

107d - Procedure Emergency Management Agency Submission

22. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home's written emergency procedures were most recently submitted on [redacted] 2024. The previous submission was dated November 29, 2022. In between, the home has changed the facility's name and the management company.

Plan of Correction ***Accept ([redacted] - 04/03/2024)***

Description of Violation The home's written emergency procedures were most recently submitted on January 18, 2024.

Violation occurred because prior Residence Director failed to timely submit homes Emergency procedures for 2023.

Plan of Correction

• The homes emergency procedures were submitted on January 18, 2024 by the Residence Director.

• The Residence Director flagged this item in State Binder as an item to be completed annually and upon any changes to the emergency procedures and will review annually to ensure completion and timely submission for each year going forward to prevent repeat violation.

• Residence Director educated Maintenance Director on the timely submission of the written emergency procedures to the local emergency management agency. Education completed on 3/13/2024.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

132a - Monthly Fire Drill

23. Requirements

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

Description of Violation

During the monthly Safety Committee meeting, in which several staff are present in varying amounts (6 in January 2024, 7 in December 2023), the monthly fire drill is planned in advance as evidenced in the meeting Agenda.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: During the monthly Safety Committee meeting, in which several staff are present in varying amounts (6 in January 2024, 7 in December 2023), the monthly fire drill is planned in advance as evidenced in the meeting Agenda.

Violation occurred because prior Residence Director failed to educate appointed person(Maintenance Director) conducting Safety committee meeting on regulation that all fire drills are to be unannounced.

Plan of Correction

• The Residence Director educated Maintenance Director as to regulation requiring fire drills to be unannounced and reviewed the appropriate agenda to follow during monthly safety committee meetings. Education completed on 3/4/2024.

• The Residence Director and or designee will attend each monthly Safety committee meeting to ensure compliance with regulation to prevent further repeat violations.

Licensee's Proposed Overall Completion Date: *03/28/2024*

132a - Monthly Fire Drill *(continued)*

Implemented [redacted] - 05/17/2024)

132g - Fire Drills Days/Times

24. 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 fire drills held on 11/22/23, 10/11/23, 09/20/23 and 08/23/23 all took place on a Wednesday.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation The fire drills held on 11/22/23, 10/11/23, 09/20/23 and 08/23/23 all took place on a Wednesday.
Violation occurred because Maintenance Director did not follow Pennsylvania's fire drill requirements.
Plan of Correction
• Residence Director educated Maintenance Director on Pennsylvania fire drill requirements on 3/4/2024
• Effective immediately, the Maintenance director will conduct unannounced monthly fire drills on alternating days and shifts.
• Effective immediately Residence Director will review fire drill record monthly to ensure compliance with regulation and to prevent repeat violations.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Not Implemented [redacted] - 05/17/2024)

181d -Storing Medication

25. 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 #7 self-administers medications. Resident #7 also shares a room with [redacted] who does not self-medicate. During the inspection on 02/26/24 there were several unlocked, unattended medications to include hair, skin and nail vitamins on a desk in the apartment. Resident #7 stated [redacted] uses a weekly pill organizer and keeps [redacted] prescription bottles in an unlocked closet. Resident #7 also said [redacted] tries to lock the front door when [redacted] leaves the apartment, and that the bedroom door does not have a lock.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation Resident #7 self-administers medications. Resident #7 also shares a room with [redacted] who does not self-medicate. During the inspection on 02/26/24 there were several unlocked, unattended medications to include hair, skin and nail vitamins on a desk in the apartment. Resident #7 stated [redacted] uses a weekly pill organizer and keeps [redacted] bottles in an unlocked closet. Resident #7 also said [redacted] tries to lock the front door when [redacted] leaves the apartment, and that the bedroom door does not have a lock.
Violation occurred Health Care Director failed to follow up on self-med administrating resident to ensure

181d -Storing Medication (continued)

compliance with regulation as it pertains to self-med administration.
Plan of Correction
• Corrected onsite at time of inspection. On 3/1/2024 Resident #7 was educated on the community's policy and state regulation for self-administration of medication. Resident resides in a 2-bedroom suite along with [redacted] and with separate bathrooms with locking bathroom cabinet. Resident #7 was provided with key to locking cabinet and obtained original containers to store medications in locked cabinet.
• Residence Director educated Health Services Director and Assistant Health Services Director on regulation pertaining to storing of medication on 3/1/2024.
• Health Care Director and Assistant Health Care Director and or designee will conduct monthly inspection of resident's rooms who self-administer medication to ensure compliance with regulation and to prevent repeat violations.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Not Implemented [redacted] - 05/17/2024)

183e - Storing Medications

26. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

During an audit on med cart #2 on [redacted] at approximately 2:35 PM, the following blister pack issues were found:

- *Resident #8's Clonazepam 0.5 MG Tab pill #6 punched and covered in medical tape,*
- *Resident #9's Tramadol 50 MG Tab - Pill 1 with a hole and pill 3 is taped shut.*

Repeat Violation: 2/27/2023 et al.

Plan of Correction ***Accept[redacted] 04/03/2024)***

Description of Violation: During an audit on med cart #2 on 02/26/24, at approximately 2:35 PM, the following blister pack issues were found: Resident #8's Clonazepam 0.5 MG Tab pill #6 punched and covered in medical tape, Resident #9's Tramadol 50 MG Tab - Pill 1 with a hole and pill 3 is taped shut.
Violation occurred due to staff not adhering to medication administration policies and procedures.
Plan of Correction
• Corrected onsite at time of inspection, blister packs containing pills that were taped shut/contained hole were removed and wasted according to narcotic handling policy by the Health Care Director and med-tech. Per inspector's recommendation reportable was completed and submitted as to potential for a narcotic diversion; however, we do not agree that it was diversion.
• Health Care Director educated med techs/nurses as to the proper medication storage and handling on 3/13/2024.
• Med techs/nurses in serviced to ensure that blister pack is intact and stored in accordance with manufacturer instructions.
• Health Services Director/Assistant Health Services and or designee will conduct monthly med cart audit. Med cart audit completed on 3/15/2024 by communities contracted pharmacy.

Licensee's Proposed Overall Completion Date: *03/28/2024*

183e - Storing Medications *(continued)*

Not Implemented [redacted] 05/17/2024)

187a - Medication Record

28. 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.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.
11. Special precautions, if applicable.
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.

Description of Violation

Resident #10 is prescribed Amoxicillin 500 MG Cap - as needed prior to dental appointment. However, resident #10's February 2024 medication administration record does not have this medication listed.

Plan of Correction ***Accept[redacted] - 04/03/2024)***

Description of Violation Resident #10 is prescribed Amoxicillin 500 MG Cap - as needed prior to dental appointment. However, resident #10's February 2024 medication administration record does not have this medication listed.
Violation occurred due to med-techs not adding prn medication to the MAR
Plan of Correction

- *Corrected onsite at time of inspection- Health Care Director removed the PRN medication from the med-cart*
- *Health services Director educated med techs/nurses on medication record regulations on 3/13/2024*
- *Health Care Director/Assistant Health Care Director and/or designee will conduct monthly MAR to Med Cart audit.*
- *MAR to CART Audit completed by homes contracted pharmacy on 3/15/2024*

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented[redacted] - 05/17/2024)

190c - Record of Training

29. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person A does not include documentation of successful

190c - Record of Training (continued)

completion of the Annual Practicum training. Additionally, all of the required actions were completed in August 2023 as opposed to being spread out over the previous year.

The home's medication administration training record for staff person D does not include documentation of successful completion of the Annual Practicum training. Additionally, all of the required actions were completed in February 2024 as opposed to being spread out over the previous year.

Plan of Correction ***Accept (- 04/10/2024)***

Observations/MAR Review was conducted for Staff Person A on by the Med Tech Trainer. Additional Observations/MAR Reviews scheduled to be performed in May and August of 2024 for the current Annual Practicum.

Observations/MAR Review was conducted for Staff Person D on /2024 by the Med Tech Trainer. Additional Observations/MAR Reviews scheduled to be performed in April and July 2024 for the current Annual Practicum.

Med Tech Trainer will be in-serviced on the requirements of 2600.190, Medication Administration Training, by the Regional Director of Operations on 4/9/2024.

Compliance monitoring on Regulation 2600.190, Medication Administration Training, will be reviewed by the Residence Director x 2 months as part of Quality Assurance meetings.

Licensee's Proposed Overall Completion Date: *04/09/2024*

Implemented 05/17/2024)

191 - Resident Right to Refuse

30. 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 #2, admitted /23, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The home could not provide signed documentation.

Plan of Correction ***Accept 04/03/2024)***

Description of Violation Resident #2, admitted /23, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error. The home could not provide signed documentation.
Violation occurred due to prior Residence Director not reviewing Resident Rights and Right to refuse medication as outlined in Resident's home contract and obtaining signature.
Plan of Correction
• We respectfully request this violation be removed as it was cited under 42e.
• Residence Director will review The resident contract that includes Residents Rights and Right to Refuse medication as outlines within 24 hours of admission and obtain resident signature.
• Residence Director educated Customer Service Assistant on the regulation and utilizing the homes resident business file audit by 3/13/2024.
• Customer Service Associate and or Residence Director will audit resident's business file upon move in for compliance with regulation utilizing resident business file audit tool.

191 - Resident Right to Refuse (continued)

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

227d - Support Plan Medical/Dental

31. 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 assessment for resident #5, dated [redacted]/23, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed", under #1 of the Bed Mobility section of the assessment. However, the LC Assessment/Evaluation Service Planning does not include:

- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*

The assessment for resident #6, dated [redacted]/23, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed", under #1 of the Bed Mobility section of the assessment. However, the LC Assessment/Evaluation Service Planning does not include:

- *Any risks associated with the device,*
- *The resident's ability to use the device safely for the intended purpose,*
- *Identification of the specific device to be used,*

The assessment for resident #10, dated [redacted]23, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed", under #1 of the Bed Mobility section of the assessment. However, resident #10 no longer uses a bed cane or any bedside mobility device.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation
The assessment for resident #5, dated [redacted]/23, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed: under #1 of the Bed Mobility section of the assessment.
The assessment for resident #6, dated [redacted]/23, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed: under #1 of the Bed Mobility section of the assessment.
However, the LC Assessment/Evaluation Service Planning for both Resident #5 and Resident #10does not include: Any risks associated with the device, The resident's ability to use the device safely for the intended purpose, Identification of the specific device to be used, If a cover is required to meet FDA guidelines.

227d - Support Plan Medical/Dental (continued)

The assessment for resident #10, dated [redacted]3, indicates "Bed Cane: uses bed cane for bed mobility, the bed cane is not used to restrict the resident's ability to get in or out of bed: under #1 of the Bed Mobility section of the assessment. However, resident #10 no longer uses a bed cane or any bedside mobility device.
Violation occurred because Health Care Director and Assistant Health Care Director were unaware of updated regulation regard bedside mobility devices.
Plan of Correction
• Corrected onsite at time of inspection Resident #5 bed mobility device was removed. Resident #5 has subsequently relocated to Florida and no longer resides in the community.
• Corrected onsite Resident #10- addendum was added to resident support plan to state that resident no longer utilizes a bed cane or bedside mobility device, bed mobility device was removed on 2/27/24
• Residence Director educated the Health Service Director and Assistant Health Service Director as to the requirements required in the resident support plan as it pertains to bed mobility/bed mobility devices on 3/15/2024.
• Ongoing, the Residence Director to review support plans as they are completed to ensure compliance with regulation for residents whose support plan states a bed mobility device is needed and in use.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

233a - Lock Approval

32. Requirements

2600.
233.a. Doors equipped with key-locking devices, electronic card operated systems or other devices that prevent immediate egress are permitted only if there is written approval from the Department of Labor and Industry, Department of Health or appropriate local building authority permitting the use of the specific locking system.

Description of Violation

The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking devices, used on the exit doors from the SDCU.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation The home does not have written approval from the Department of Labor and Industry, Department of Health or local building authority for the magnetic locking devices, used on the exit doors from the SDCU.
Violation occurred because prior Residence Director failed to keep record of written approval from the Department of Labor and Industry for the magnetic locking devices, used on exit doors from the SDCU,
Plan of Correction
• The Residence Director contacted Department of Labor and Industry and they came on site on 3/16/2024. Written approval for magnetic locking device used on the exit doors from the SDCU will be received by 3/31/2024.
• The Residence Director will ensure written approval is secured in state binder along with manufacturer letter for magnetic locking devices installed on homes SDCU exit doors.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] - 05/17/2024)

234a -

33.

234b -

[redacted]

252 - Record Content

35. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #4's record does not include the resident's race or a photograph of the resident that is no more than 2 years old.

Plan of Correction ***Accept [redacted] - 04/03/2024)***

Description of Violation: Resident #4's record does not include the resident's race or a photograph of the resident that is no more than 2 years.
Violation occurred because person responsible for entering race on resident record missed the field of entry and failed to update resident photo.
Plan of Correction
• Resident #4's record was updated to include race with an updated photo effective 3/15/2024.
• Residence Director educated the Health Services Director and Assistant Health services director as to the items required to be noted in the resident's record upon admission along with updated photo of resident to be less than 2 years old on 3/15/2024.
• Health Care Director or Assistant Health Care Director will audit all resident charts for resident's race or a photograph of the resident that is no more than 2 years and correct by 4/15/2024.
• Upon admission Health Care Director and Assistant Health Care Director will review record content to ensure it meets the items listed in the regulation.
• Residence Director and or designee will audit new move in record content for compliance monthly along with confirming current photo in place.

Licensee's Proposed Overall Completion Date: *03/28/2024*

Implemented [redacted] 05/17/2024)

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *THE PROVINCE OF SOUTHAMPTON* **License #**: *14538* **License Expiration**: *07/17/2024*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

Name: [redacted]

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*

Address: [redacted]

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/10/2019* **Issued By**: *upper Southampton township*

Staffing Hours

Resident Support Staff: **Total Daily Staff**: *108* **Waking Staff**: *81*

Inspection Information

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

Reason: *Monitoring* **Exit Conference Date**: *04/29/2024*

Inspection Dates and Department Representative

04/29/2024 - On-Site [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *62*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *36* **Residents Served**: *16*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

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

Have Mobility Need: *46* **Have Physical Disability**: *3*

Inspections / Reviews

04/29/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/27/2024*

06/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *05/27/2024*

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

06/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/18/2024*

09/10/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *06/17/2024*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

5a1 - DHS Access

1. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
1. Agents of the Department.

Description of Violation

On 04/29/2024, an agent of the Department, requested access to resident medication administration records. Staff person A, the administrator did not have access to the records, and could not provide them while an agent of the Department was onsite.

Plan of Correction ***Accept [redacted] - 06/10/2024)***

The deficiency occurred during the inspection due to Staff Person A not having access. eMar access had been restricted, and an eMar support person could not reset the password. Additionally, the Med Tech on duty needed help finding the medication administration record MAR on eMar.

Staff Person A has now received access to eMar, and all Med-Techs were educated on accessing the Medication Administration Record (MAR) on EMar for a resident. The Administrator retrained to all Med Techs/LPNs/HCD/AHCD on Regulation 5a, Access, completed by 5/24/24.

The process to access the Medication Administration Record (MAR), also known as the Medication Sheet on EMar for a resident, has been placed in the Med Tech Training Binder housed in the Chartroom for easy access to prevent further violations. Compliance will be conducted x 2 quarters as part of Quality Assurance meetings by the Administrator, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented[redacted] 06/24/2024)

62 - Contact List

2. Requirements

2600.
62. List of Staff Persons - The administrator shall maintain a current list of the names, addresses and telephone numbers of staff persons including substitute personnel and volunteers.

Description of Violation

Staff person A, the [redacted] maintains a list of staff persons that does not include substitute personal.

Plan of Correction ***Accept [redacted] - 06/13/2024)***

The deficiency occurred because the Administrator/Designee failed to maintain a printed list of substitute staff contact information. Substitute staff/Agency contact information was housed electronically in the substitute staff/agency platform.

On 4/30/24, the Administrator updated the Agency/Substitute Staff Binder to include the Roster of Substitute personnel. On 5/21/24, the Administrator retrained the Healthcare Director/designee on Regulation 62, Contact List, which requires the contact information of the substitute staff to be added upon assigning the shift to a substitute staff member.

62 - Contact List (continued)

As part of their commitment to maintaining compliance, the Administrator will conduct a monthly review of the Agency/Substitute Staff Binder.
starting 6/1/2024. This regular review is a preventive measure aimed at avoiding further violations. Additionally, the Administrator will include compliance checks twice a quarter effective 6/1/24 as part of the Quality Assurance meetings, and the relevant information will be appropriately retained.

Proposed Overall Completion Date: 05/27/2024
Proposed Overall Completion Date: 06/12/2024

Licensee's Proposed Overall Completion Date: *06/12/2024*

Not Implemented [redacted] - 06/24/2024)

65a - FS Orientation 1st Day

3. Requirements

2600.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was [redacted]24, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

Plan of Correction ***Accept[redacted] - 06/13/2024)***

The deficiency occurred because the Administrator/designee failed to ensure that a process was in place when not in the community to ensure Agency/substitute staff were provided training on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.

65a - FS Orientation 1st Day (continued)

The home's Safety Checklist, a comprehensive document outlining the topics in Regulation 65.a, was meticulously added to the Agency/Substitute binder on 4/30/24. It is designed to be reviewed with substitute staff by a community staff person at the start of each shift. Once the trainer and substitute/agency staff sign off, completion is recorded in the Agency/Substitute Binder, ensuring a systematic staff training and compliance approach.

In a proactive response to the deficiency, the Administrator promptly took corrective action. They conducted a retraining session for the MD/HCD/AHCD/Med Techs on Regulation 65.a, FS Orientation 1st Day, with a specific focus on ensuring the completion of the Safety Checklist with all Agency/substitute staff at the start of their assigned shift. Retraining was completed on 5/24/2024. This proactive measure not only addresses the deficiency but also ensures future compliance.

As part of their commitment to maintaining compliance, the Administrator will conduct a monthly review of the Agency/Substitute Staff Binder starting 6/1/24 This regular review is a preventive measure aimed at avoiding further violations. Additionally, the Administrator will include compliance checks twice a quarter as part of the Quality Assurance meetings, and the relevant information will be appropriately retained starting 6/1/2024

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *06/12/2024*

Implemented [redacted] - 06/24/2024)

103g - Storing Food

4. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

A rack of desserts in the walk-in refrigerator was opened and unsealed.

Containers of corned beef, cabbage, and kung pao, in the walk-in refrigerator was unsealed due to large holes poked in the top of the saran wrap.

Plan of Correction ***Accept [redacted] - 06/10/2024)***

The home failed to ensure food was stored in closed or sealed containers. A rack of desserts was uncovered in the walk-in. The walk-in refrigerator's containers of corned beef, cabbage, and kung pao were unsealed due to large holes poked in the top of the saran wrap.

This was corrected on-site at the time of inspection. The cook immediately covered the dessert rack and discarded corned beef, cabbage, and kung pao containers in the walk-in refrigerator.

The Culinary Director retrained all dining staff on Regulation 103g, Food Service, regarding dating, labeling, and covering items. This also included cooling food in larger containers to avoid venting saran wrap and ensuring food was securely covered. The education was completed by 5/22/24.

The Culinary Director purchased individual dessert tray covers on 5/5/24 and implemented them with all staff to ensure compliance. This training was part of the 103g Food Service training completed by 5/22/24.

103g - Storing Food (continued)

Beginning 5/22/24, the Culinary Director/designee must complete the Dining Checklist daily to maintain compliance. The Administrator will conduct compliance x 2 quarters as part of Quality Assurance meetings, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Not Implemented [redacted] 06/24/2024)

103i - Outdated Food

5. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated package of unknown factory sealed meat in a bin with other labeled meats in the walk in freezer.

Plan of Correction ***Accept [redacted] - 06/10/2024)***

This deficiency occurred because the cook failed to recognize that the sealed meat was not labeled. It was removed from the box that it was shipped in, which contained the information, including the expiration date.

This was corrected on-site at the time of inspection. The cook immediately discarded the undated package of unknown factory-sealed meat from the walk-in refrigerator.

The Culinary Director took a significant step by retraining all dining staff on Regulation 103i, Food Service, specifically focusing on dating, labeling, and covering items. The education will be completed by 5/22/24.

To maintain compliance, the Culinary Director/designee must complete the Dining Checklist daily from 5/22/24. The Administrator will conduct compliance x 2 quarters as part of Quality Assurance meetings, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Not Implemented [redacted] 06/24/2024)

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 on the 29th of the month as evidenced by the following drills 1/29/2024, 2/29/2024, and 3/29/2024. On 4/29/2024, there had not yet been a fire drill held for the month of April 2024.

132g - Fire Drills Days/Times *(continued)*

Plan of Correction ***Accept [redacted] - 06/11/2024)***

The deficiency occurred because the Maintenance Director did not fully understand the regulations and did not have a varying pattern as to the time and day of fire drills.

After multiple in-services, the former Maintenance Director did not fully understand Regulation 132g. On 5/21/24, the Administrator educated the newly hired Maintenance Director on Regulation 132g, Fire Drills, and past violations to ensure compliance.

As part of our systematic approach to maintaining compliance, the Administrator will conduct compliance monitoring on Regulation 2600.132g Fire Drill Days/Times twice a year during Quality Assurance meetings. All records will be diligently retained for reference.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Not Implemented [redacted] - 06/24/2024)

144c1 - Smoking Area Guidelines

7. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On [redacted]/2024, at 12:21 pm, staff members C and D were observed smoking next to the building, outside the resident dining room patio. This is not the home's designated smoking area. The home's designated smoking area is outside by the dumpsters away from the building.

Plan of Correction ***Accept[redacted] - 06/13/2024)***

The deficiency occurred because staff members C and D did not abide by company policy on Smoking in the Campus's designated smoking area, which is located away from the building.
Administrator took Immediate action on 4/29/24 to ensure signs were posted to designate that it was a nonsmoking area.
The Administrator retrained All Staff on 5/24/24 on Regulation 144c, Use of Tobacco, and designated smoking areas. Rounds of perimeter of building will be done daily by Administrator and or designee (management team member/Manager on Duty) to ensure compliance with the regulation and to prevent further incidents starting 6/12/2024

Compliance will be conducted x 2 quarters as part of Quality Assurance meetings by the Administrator, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *06/12/2024*

144c1 - Smoking Area Guidelines *(continued)*

Implemented [redacted] - 06/24/2024)

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 [redacted] room. Resident 2's [redacted] does not self administer medications and resides in the same unit. On 4/29/2024, at 10:13 am, there were several unlocked, unattended medications to including white pills in a plastic 4oz ramekin which the resident stated was Tylenol in resident 1's bathroom cabinet. The cabinet was not locked, and the resident's bedroom door does not lock.

Plan of Correction ***Accept[redacted] - 06/11/2024)***

The deficiency occurred due to a misunderstanding of the regulation, encompassing over-the-counter and prescription medications. This is a crucial regulation that all staff members, particularly Resident #1, must be fully aware of and comply with.

The Administrator provided a written explanation of the regulation in a format that Resident #1 would understand so that Resident #1 could reference it to ensure compliance. Resident #1 understood the policy and what she needed to do to comply with the regulation.

The Administrator retrained All Direct Care Staff on 5/24/24 on Regulation 181d, Storing Medications.

Beginning 5/20/24, the HCD/Designee will sweep the rooms of all self-medicating residents weekly to ensure compliance. Compliance will be conducted x 2 quarters as part of Quality Assurance meetings by the Administrator, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Not Implemented [redacted] - 06/24/2024)

183a - Original Containers and Injections

9. Requirements

2600.
183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

Description of Violation

On 4/29/2024, at 10:13 am, Tylenol for resident 1 was in an unlabeled 4 oz plastic container. This medication is not on resident 1's medication list.

183a - Original Containers and Injections *(continued)*

Plan of Correction ***Accept [redacted] - 06/11/2024)***

The deficiency occurred because Resident #1 did not understand that the regulation included over-the-counter medication and thought it only applied to prescriptions.

The Administrator provided a written explanation of the regulation in a format that Resident #1 would understand so that Resident #1 could reference it to ensure compliance.

The Healthcare Director obtained new Tylenol orders for Resident #1 from a physician and added them to the medication list on 5/20/24.
The Administrator retrained All Staff on 5/24/24 on Regulation 183a, Original Containers and Injections.

Beginning 5/20/24, the HCD/Designee will sweep the rooms of all self-medicating residents weekly to ensure compliance. Compliance will be conducted x 2 quarters as part of Quality Assurance meetings by the Administrator, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

Implemented [redacted] - 06/24/2024)

183d - Prescription Current

10. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 4/29/2024, Tylenol that was not prescribed for resident 1, was in the resident's unlocked medication cabinet.

Plan of Correction ***Accept ([redacted] 11/2024)***

The deficiency occurred because Resident #1 did not understand that the regulation included over-the-counter medication and thought it only applied to prescriptions.

The Administrator provided a written explanation of the regulation in a format that Resident #1 would understand so that Resident 1 could reference it to ensure compliance.

The Healthcare Director obtained new Tylenol orders for Resident #1 from a physician and added them to the medication list on 5/20/24.
The Administrator retrained All Direct Care Staff on 5/24/24 on Regulation 183d, Prescription Current.

Beginning 5/20/24, the HCD/Designee will sweep the rooms of all self-medicating residents weekly to ensure compliance. Compliance monitoring will be conducted x 2 quarters as part of Quality Assurance meetings by the Administrator, and the information will be retained accordingly.

Proposed Overall Completion Date: 05/27/2024

Licensee's Proposed Overall Completion Date: *05/27/2024*

183d - Prescription Current *(continued)*

Implemented [redacted] 06/24/2024)

183e - Storing Medications

11. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

A blister pack of Clonazepam 1 mg tabs, orally 4 times daily, for resident 3 had pill #9 punched in the back and covered with a piece of surgical tape.

A blister pack of Oxycodone HCL 5 mg tabs, 1 every 4 hours as needed for pain, for resident 4 had pill #79 punched and the back of the pill was stuck to scotch tape which was holding the pill inside.

Plan of Correction ***Accept [redacted] - 06/13/2024)***

The deficiency occurred due to the direct care staff's oversight in auditing the medication cart thoroughly, leading to non-compliance with the regulation. It's crucial to remember that such lapses can have serious implications, underscoring the importance of diligent adherence to the med cart audit process.

The Administrator retrained all Direct Care Staff on Regulation 183e, Storing Medications on 5/24/24, regarding the proper med cart audit process, visual inspection of the back of packaging on narcotics for alteration, and removal and waste of medication according to the policy if found to not comply with the regulation. An educational sheet with written instructions was provided, and a copy will be kept in the Med Tech Training Binder for med techs to reference.

Beginning 5/20/24, Third-shift direct care staff are assigned nightly med cart audits for 4 weeks, then weekly thereafter. The Healthcare Director/Designee will complete a weekly med cart audit beginning 5/24/24 for 4 weeks and then monthly thereafter to ensure compliance.

Proposed Overall Completion Date: 05/27/2024
Proposed Overall Completion Date: 06/12/2024

Licensee's Proposed Overall Completion Date: *06/12/2024*

Not Implemented [redacted] - 06/24/2024)