Department of Human Services

Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

August 14, 2024

, ADMINISTRATOR
2901 HARRISBURG PIKE OPERATING COMPANY LLC

RE: OAK LEAF MANOR NORTH
2901 HARRISBURG PIKE
LANDISVILLE, PA, 17538
LICENSE/COC#: 33821

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/15/2024, 05/16/2024, 05/17/2024 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: *OAK LEAF MANOR NORTH* **License #**: *33821* **License Expiration**: *11/21/2024*

Address: *2901 HARRISBURG PIKE, LANDISVILLE, PA 17538*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *2901 HARRISBURG PIKE OPERATING COMPANY LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *10/20/2015* **Issued By**: *East Hempfield Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *125* **Waking Staff**: *94*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *05/17/2024*

Inspection Dates and Department Representative

05/15/2024 - On-Site:
05/16/2024 - On-Site:
05/17/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served**: *96*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Friendship* **Capacity**: *34* **Residents Served**: *26*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *96*

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

Have Mobility Need: *29* **Have Physical Disability**: *1*

Inspections / Reviews

05/15/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/13/2024*

Inspections / Reviews *(continued)*

06/14/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2024*

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

06/24/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *08/01/2024*

08/14/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2024*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

18 - Compliance With Laws

1. 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 Clean Indoor Air Act requires that the home post a sign at each entrance that states, "Smoking Permitted in Designated Areas Only" or "No Smoking". On 05/17/2024, signs were not posted at the home's entrances.

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

"Smoking is only permitted in designated area" sign placed on front door by Administrator on 5/17/2024. completed an audit of all entrance doors to ensure all entry doors have appropriate signage on 6/3/2024. A task has been added by to the Monthly maintenance plan to have all entrance doors checked for appropriate signage. If signage is removed, damaged or faded in any way, sign is to be replaced. This monthly check is to be completed by Maintenance Director monthly start July 1, 2024. Administrator will review importance of appropriate smoking signage to all exit doors in all staff meeting scheduled 6/27/2024. Attachments include, Initial Audit Complete by Printout of Monthly task to be completed by maintenance Director and photo of Front door with signage posted.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 08/06/2024)

25a - Written Contract and Review

2. 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

The following residents have contracts pre-dating the change of legal entity in 2023:
Resident 1- Contract signed on
Resident 2- Contract signed on
Resident 3- Contract signed on
Resident 4- Contract signed on .

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

An Addendum to our current contract will be completed by our Chief Operating Officer to reflect the legal change in entity and the previous signed contract remains valid. This addendum will be completed by June 30, 2024. Once Addendum is completed Administrator will obtain signatures of Power of Attorney and/or residents who resided within the facility prior to the legal entity change in 2023. These signatures will be obtained by August 31 2024. Audit to be completed by June 30th of all residents who resided within the facility prior to legal entity change by Administrator Administrator will review updated contract with Sales Representative for Oak Leaf Manor North once New contract is received on July 1st 2024, and explain the importance of the new/update contract. administrator will begin a quarterly audit of all resident's contract to ensure the correct contract is utilized and has appropriate signature starting September 1st 2024.

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 08/14/2024)

42b - Abuse

3. Requirements

2600.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Staff Member A was terminated from employment on [redacted] after an internal investigation into several reports of verbal and physical abuse towards residents was reported by additional staff members. Incidents of the abuse include:
Staff Member A would purposely turn Resident 5's room lights on after being told by the resident to please keep them off.
Staff Member A told Resident 6 [redacted] is a "[redacted]", and that Resident 6 "gets under [redacted] skin and is annoying". Staff Member A has also told Resident 6 to "stop sneaking up on me and to leave me alone".
Staff Member A has told Resident 7 that [redacted] is "weird and stupid".
Staff Member A has startled Resident 8 when waking [redacted] and has told the Resident to "shut up and stop screaming, you need to relax".
On 05/01/2024, Staff Member A has belittled and humiliated Resident 8 in front of other residents and staff.
Staff Member A has told Resident 9 to "get out of my face and leave me alone, you're [redacted] annoying".
On 05/01/2024, Staff Member A grabbed Resident 10 by [redacted] pants and threw [redacted] into bed. The resident struggled to orient [redacted] and another staff member intervened to assist the resident.

Repeated Violation - 09/25/2023, et al

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

Staff member A was suspended pending investigation immediately following reports of alleged abuse. Verbal report was made immediately to Office of Aging and followed by an Act 13. An internal investigation was completed by [redacted] and [redacted]. Once that investigation was completed, Staff member A was terminated on [redacted] HR Generalist to complete a criminal background check and/or FBI check as appropriate of all potential new employees prior to hire. This is something that is already in place and will continue indefinitely. All Staff members will be required to complete a Relias based training "Preventing, recognizing and reporting Abuse". This training must be completed by July 31. 2024. Staff meeting scheduled for 6/27/2024 in which Abuse Reporting will be addressed by Administrator. Administrator will complete 5 random resident interviews on a quarterly basis to ensure resident feel treated with dignity and respect starting July 1st, 2024. Attachments include Staff Meeting Agenda and Relias Training Overview

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/14/2024)

105g - Lint Removal and Duct Cleaning

4. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 05/17/2024 at 11:11AM, the lint trap in Dryer 1 of the 1st floor secure dementia care unit (SDCU) had a thick accumulation of lint in the lint trap. The dryer was not in use at the time of the observation, and there were no clothes in the dryer.

105g - Lint Removal and Duct Cleaning *(continued)*

Plan of Correction ***Accept (- 06/14/2024)***

Lint was removed from affected dryer immediately after inspection by Maintenance Director. A sign stating " Lint Trap MUST be cleaned after each use" was placed on all facility dryers by on 6/10/2024. All staff members to be educated on the importance of removing Lint immediately from those dryers and the hazards involved at the next scheduled staff meeting on 6/27/2024 by Administrator, to conduct a random daily audit of Dryer Lint contents starting 6/17/2024 for one week, then weekly for 4 weeks. A monthly audit will be completed by the housekeeping supervisor starting July 22. 2024 to ensure compliance. Attachments include Staff Meeting Agenda and picture of Lint Signage applied to dryer.

Licensee's Proposed Overall Completion Date: *07/22/2024*

Implemented (- 08/06/2024)

109b - Rabies Vaccination

5. Requirements

2600.
109.b. Cats and dogs present at the home shall have a current rabies vaccination. A current certificate of rabies vaccination from a licensed veterinarian shall be kept.

Description of Violation

On 05/15/2024, the home did not have current certificates of rabies vaccinations for the cat living in room and the cat living in room

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

Rabies Vaccination was obtained for Cat) on 5/21/24 by Vet Services. Rabies Vaccination was obtained for Cat on 5/15/2024. Vaccination Records Attached. All current animals compliant with Vaccination records as of 6/12/2024. to complete a 6-month audit of all animals within facility to ensure proper vaccinations records are obtained. Next 6-month audit will be completed by on December 2024. Attachments include both cats vaccination records and current pet audit. Administrator provided education to resident and Resident on 5/15/2024 on the importance and necessity of having a current rabies vaccine for their pet.

Licensee's Proposed Overall Completion Date: *06/19/2024*

Implemented (- 08/06/2024)

171b5 - First Aid Kit

6. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include: thermometer, tweezers and eye coverings.

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

Thermometer, tweezers and eye coverings added to first aid bus kit by 6/10/2024. Activities Director to complete a weekly audit on the first aid kit to ensure all contents are present and not expired starting June 24th 2024. A paper has been created by Administrator on 6/14/2024 and placed inside first aid kit to be

171b5 - First Aid Kit (continued)

completed when any items are utilized. The document is to be submitted to Activities Director so items can be replaced immediately. All staff members will be educated on the importance of notifying director when items are used and first aid kit remains in compliance at next staff meeting scheduled June 27th, 2024, by [REDACTED] Attachments include Staff Meeting agenda, First Aid Kit Usage Form and First Aid Kit Check completed on 6/10/24 by [REDACTED]

Licensee's Proposed Overall Completion Date: *06/27/2024*

Implemented ([REDACTED] - 08/06/2024)

183e - Storing Medications

7. 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

On 05/17/2024 at approximately 1:00PM, half of a round white pill was found lose in the medication drawer of the A Hall med cart.

On 05/17/2024 at approximately 2:00PM, half of a round red pill was found lose in the medication drawer of the 2nd Floor secure dementia care unit (SDCU) med cart.

Plan of Correction ***Accept ([REDACTED] - 06/14/2024)***

Loose pills in question were removed immediately following inspection by Director of Wellness on 5/17/2024. All Medication Technicians educated on the importance of ensuring medication are stored in an organized manner under proper conditions at Medication Technician meeting scheduled on June 19 2024 by Director of Wellness. Director of Wellness to complete an audit of all medication carts on June 14, 2024, and monthly thereafter ensuring compliance. Attachments include Medication Technician Meeting agenda

Licensee's Proposed Overall Completion Date: *06/19/2024*

Implemented ([REDACTED] - 08/06/2024)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 05/17/2024 at 1:33PM, Resident 3's glucometer was calibrated to 04/16/2024 at 1:43PM.

On 05/06/2024, Resident 3 had a blood sugar reading of 129 in [REDACTED] glucometer. However, the blood sugar reading was not documented in the medication administration record (MAR).

Resident 11's MAR had the following blood sugar readings incorrectly documented on [REDACTED] MAR:
On 05/02/2024 at 12:00PM, the blood sugar reading is documented as 120 in the MAR. However, the reading in the glucometer is 122.

185a - Implement Storage Procedures (continued)

On 05/03/2024 at 8:00PM, the blood sugar is documented as 331 in the MAR. However, the reading in the glucometer is 338.

On 05/17/2024, Resident 4's PRN polyethylene glycol 3350 SM and PRN ready to use enema 133ML were not available in the home.

On 05/17/2024, Resident 9's PRN nitroglycerin ling 0.4MG spray was not available in the home.

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

Resident 3 glucometer was recalibrated by Director of Wellness on 6/13/2024. PRN Medications for Resident 4 and Resident 9 were ordered by Director of Wellness from Pharmacy and currently in stock. Director of Wellness to complete a glucometer reading audit to ensure glucometer readings match documentation 6/14/2024. this audit will be repeated weekly until July 31 2024 then monthly. All Medication Technicians educated on the importance of calibrating glucometer machines, documenting results and proper access to all medications at Medication Technician meeting scheduled on June 19 2024 by Director of Wellness. Director of Wellness to complete an audit of all PRN medications are available and on site by June 26th, 2024. Director of Wellness to complete a monthly audit starting July 2024 to ensure compliance. Attachments include Medication Technician meeting agenda.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (█ - 08/14/2024)

190a - Completion Medication Course

9. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff Person B, who has not successfully completed the Department-approved medications administration course, administered various medications to various residents on the following dates:
04/28/2024
04/30/2024
05/01/2024
05/02/2024
05/03/2024
05/05/2024
05/06/2024
05/07/2024
05/10/2024
05/11/2024

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

Staff member B was immediately removed from the position of Medication Technician on 5/17/2024. The staff member will complete the full Department- approved Medication Administration course before returning this

190a - Completion Medication Course (continued)

position. Administrator [redacted] completed an audit of all Medication Technicians paperwork on staff on 6/7/2024 and will complete a quarterly audit going forward starting September 2024. Any new employees hired as medication technicians will not be permitted to start on the floor until appropriate documentation is obtained. Administrator to provide education to HR generalist and Director of Wellness on June 24th on importance of obtaining appropriate documentation for Medication Technicians before working on the floor.

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 08/14/2024)

227d - Support Plan Medical/Dental

10. 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

On [redacted] Resident 10 was admitted to the home on hospice. However, the resident's current support plan, dated [redacted], does not include this.

Repeated Violation - 09/25/2023, et al

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

Resident 10 RASP was updated with information stating resident is receiving hospice services upon admission by Administrator [redacted] on 6/7/2024. An audit of all RASP for the secured memory care unit residents will be conducted by Administrator [redacted] This audit will be completed by July 1, 2024. Any corrections will be made at the time of audit by [redacted] Administrator. A quarterly Audit will be completed by the Memory Care Coordinator starting September 2024. An annual audit will be completed by [redacted] Administrator to ensure continued compliance, this audit will be scheduled for January 2025. Administrator to provide education to a nursing managers which include Director of Wellness, Resident Care Coordinator, Memory Care Coordinator and Dementia Program Director on June 24th 2024 on importance of updating RASP and ensuring accurate information is documented. Attachments included Resident 10 corrected RASP.

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

Implemented (- 08/06/2024)

231b - Medical Evaluation

11. Requirements

2600.
231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted] however, the resident's most recent medical evaluation was completed on [redacted] and does not state a need for the resident to be served in a SDCU.

231b - Medical Evaluation (continued)

Resident 10 was admitted to the SDCU on [redacted]; however, the resident's most recent medical evaluation was completed on [redacted] and does not state a need for the resident to be served in a SDCU.

Resident 8 was admitted to the SDCU on [redacted]; however, the resident's most recent medical evaluation was completed on [redacted] and does not state a need for the resident to be served in a SDCU.

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

Residents 5, 8 and 10 medical evaluations were corrected to reflect the need for resident to be served in SDCU by [redacted] on 6/12/2024. Administrator [redacted] verbally discussed changes made to Medical Evaluation with PCP for all Resident [redacted] and received verbal confirmation on that change. PCP [redacted] will initial change on DME when completing rounds in the facility on 6/18/2024. Administrator [redacted] to complete an audit of all resident current Medical evaluation who reside on secured memory care unit to ensure all reflect the need for the resident to be served in a SDCU. This audit will be completed by July 1 2024. Any corrections will be made at the time of audit by [redacted] Administrator and confirmed with appropriate PCP. A quarterly Audit will be completed by the Memory Care Coordinator starting September 2024. An annual audit will be completed by [redacted] Administrator to ensure continued compliance, this audit will be scheduled for January 2025. Administrator to provide education to a nursing managers which include Director of Wellness, Resident Care Coordinator, Memory Care Coordinator and Dementia Program Director on June 24th 2024 regarding the importance of appropriate DME documentation. Attachments include Resident 5,8 and 10 corrected DME form

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 08/06/2024)

231e - No Objection Statement

12. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident 5 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

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

Administrator [redacted] spoke with Resident 5 POA regarding objection to resident admission to secured Dementia Care Unit on 9/16/2023. Resident POA verbally expressed [redacted] does not have any objections to [redacted] residing on the secured memory care unit. Resident 5 is currently in the hospital, therefor unable to address potential objection although [redacted] will attempt to get resident signature once returned. [redacted] emailed appropriate paperwork to Resident 5 POA for signature and instructed to return As soon as Possible. [redacted] will follow up with resident POA if not received by 6/21/24. Administrator [redacted] will complete an initial audit of all residents residing on secured memory care unit to ensure all residents have appropriate documentation. This audit will be completed by 6/21/24. A quarterly Audit will be completed by the Memory Care Coordinator starting September 2024. An annual audit will be completed by [redacted] Administrator to ensure continued compliance, this audit will be scheduled for January 2025. [redacted] documented in resident's chart via Nurses Notes on verbal communication with POA. Administrator to provide education to a nursing managers which include Director of Wellness, Resident Care Coordinator, Memory Care Coordinator and Dementia Program Director on

231e - No Objection Statement (continued)

June 24th 2024 regarding proper paperwork and documentation of all secured dementia care residents.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented (- 08/14/2024)

231h - Resident-Home Contact

13. Requirements

2600.
231.h. The resident-home contract specified in § 2600.25 (relating to resident-home contract) must also include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees.

Description of Violation

The resident-home contract, for the following residents do not include a disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees associated with the Secure Dementia Care Unit (SDCU) and placement within the SDCU:
Resident 5 admitted on
Resident 6 admitted on .
Resident 7 admitted on .
Resident 8 admitted on .
Resident 9 admitted on
Resident 10 admitted on

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

An Addendum to our current contract will be completed by our Chief Operating Officer to reflect the addition of disclosure of services, admission and discharge criteria, change in condition policies, special programming and costs and fees associated with the Secure Dementia Care unit. This addendum will be completed by July 31st, 2024. Once Addendum is completed Administrator will obtain signatures of Power of Attorney and/or residents currently residing in our Secured Memory Care Unit by August 31, 2024. Chief Operating Officer will be submitting an updated contract with appropriate changes to SDCU resident contracts to be completed by July 31 2024, any new admissions after that date will sign this updated contract and not an addendum. Administrator will review updated contract with Sales Representative for Oak Leaf Manor North once New contract is received on July 1st, 2024 and explain the importance of the new/update contract. administrator will begin a quarterly audit of all resident's contract to ensure the correct contract is utilized and has appropriate signature starting September 1st 2024.

Licensee's Proposed Overall Completion Date: *09/01/2024*

Implemented (- 08/06/2024)

233c - Key-Locking Devices

14. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 05/15/2024 at approximately 10:30AM, the emergency exit located in the Secure Dementia Care Unit (SDCU) courtyard had the incorrect passcode posted.

233c - Key-Locking Devices *(continued)*

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

Correct passcode was obtained and conspicuously posted to emergency exit immediately following inspection on 5/15/2024 by Administrator A monthly audit will be completed by Administrator beginning 7/1/2024 to ensure signage is compliant with all appropriate regulations and in working order. Attachments include Secured Memory Care door Signage that was replaced. Administrator to review importance of Secured Memory Care Door Signage with Maintenance Director and Memory Care Managers including Dementia Care Director and Memory Care Coordinator on June 24th 2024.

Licensee's Proposed Overall Completion Date: *07/01/2024*

Implemented (- 08/06/2024)