pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

Located at **80 WEST MILLPORT ROAD, LITITZ, PA 17543**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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

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

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

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

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

and shall remain in effect from **November 12, 2024** until **May 12, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **332982**

ISSUING OFFICER

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED

MAILING DATE: NOVEMBER 12, 2024

Lititz PCH LLC
80 West Millport Road
Lititz, Pennsylvania 17543

RE: Legend Personal Care and Memory Care of Lititz
80 West Millport Road
Lititz, Pennsylvania 17543
License #: 33298

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living), licensing inspections on July 2-3, 2024 and September 19-20, 2024 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

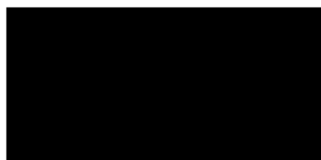
As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on our acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) and 55 Pa. Code §20.71(a)(2);(4) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed.

If you disagree with the decision to issue a SECOND 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision. If you decide to appeal, a written request for an appeal must be received within 10 days of the date of this letter by:

Lestia Fetzer
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.

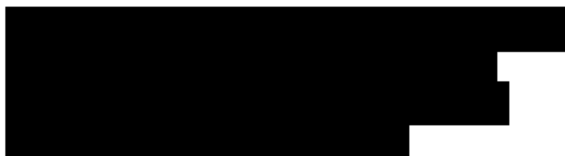
Sincerely,



Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc:



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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LITITZ* **License #**: *33298* **License Expiration**: *09/18/2024*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA 17543*

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

Administrator

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

Legal Entity

Name: *LITITZ PCH LLC*
Address: [redacted]

Certificate(s) of Occupancy

Type	Date	Issued By
I 1	11/08/2016	Warwick Township
I 2	11/08/2016	Warwick Township
Other	11/08/2016	Warwick Township

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *74* **Waking Staff**: *56*

Inspection Information

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

Reason: *Provisional* **Exit Conference Date**: *07/03/2024*

Inspection Dates and Department Representative

07/02/2024 On Site: [redacted]
07/03/2024 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *memory care* **Capacity**: *40* **Residents Served**: *24*

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *70*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *28* **Have Physical Disability**: *1*

Inspections / Reviews

07/02/2024 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/25/2024*

07/30/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/06/2024*

08/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/02/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/02/2024*

10/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/02/2024*

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 7/2/24, at approximately 9:30 AM, an agent of the Department, requested access to the home's list of staff that includes their name, date of hire, job titles, contact information, background checks, trainings, and files, and requested access to the home's list of residents that includes their name, date of admission, date of birth, and demographic information to indicate if they were self-administering of medications, took insulin, had a sliding scale to follow for insulin administration, diagnosis, dietary and mobility needs, hearing impairments, physical disabilities, etc.

By the exit conference on 7/3/24 at approximately 5:00 PM, the home had not provided an agent of the Department with a full and complete list of staff persons, their dates of hire, and job titles. The home did not provide a list of residents that included identifying demographic information until approximately 12:00 PM on 7/2/24. Additionally, around 12:00 PM on 7/3/24, the agents of the Departments identified a resident who is hard of hearing and two residents that were self-administering medications that were never identified as such to the agents of the Department by the home when requested on 7/2/24.

Plan of Correction ***Accept (█ - 08/06/2024)***

Beginning 7/4/24, the Administrator/designee shall ensure that the department has immediate access to the home, the residents, and records for department agents.

On 7/8/24, the Administrator developed a list of all temporary agency staff, including their start dates and positions.

By 8/7/24, the Administrator/designee will re-educate all current managers and associates regarding regulation 5.a.1, including where and how to access this information easily should the administrator or designee not be present during a future inspection. Documentation shall be kept.

The Administrator/designee shall review and modify the list of current residents and associates by 7/31/24 and weekly thereafter, which will include the additional information documented in the description of the violation section of the LIS.

Beginning 7/25/24, our regularly scheduled monthly Quality Assurance meetings will rigorously monitor adherence to 2600.5a1, DHS Access. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/08/2024*

Implemented (█ - 10/21/2024)

15a - Resident Abuse Report

2. Requirements

2600.

15a - Resident Abuse Report *(continued)*

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at the afternoon shift-change, Direct Care Staff Member A was assisting Resident #3 in the bathroom but left him/her in the bathroom when Staff Member A's shift ended at 3 PM. Oncoming staff discovered Resident #3 in the bathroom, alone, covered in bowel movement. The resident's support plan, dated [redacted], states that the resident needs total physical assistance with toileting which was not provided on [redacted]. The home did not report this allegation of neglect to the local Area Agency on Aging.

Plan of Correction ***Accept ([redacted] - 08/06/2024)***

Beginning 7/3/24, the Administrator/designee shall report allegations of abuse or neglect to the Departments of Human Services and Aging in accordance with the Older Adult Protective Services Act (OAPSA).

The Administrator reported the neglect allegation on 7/3/24 in accordance with the Older Adult Protective Services Act (OAPSA). Documentation will be kept.

Effective 7/3/24 and ongoing, the Administrator/designee shall meticulously review all resident incident reports on or before the next business day after they occur, ensuring that any allegation of abuse per the OAPSA is reported, as required.

The Administrator attended the Pennsylvania Assisted Living Association Abuse and Neglect conference on 7/24/24.

The Administrator/designee in a commitment to continuous improvement, the Administrator/designee shall re-educate current associates on reporting suspected abuse of a resident by 8/2/24 per regulation 2600.15a and OAPSA. Documentation shall be kept.

By 8/9/24, the Administrator/designee shall audit six months of resident incidents to ensure proper reporting to AAA has been completed per regulation 2600.15(a). Any allegations of abuse and neglect found from this audit shall be reported as required, and documentation of the audit and reporting, if applicable, shall be kept.

Beginning 7/25/24, adherence to 2600.15a, Resident Abuse Report, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/10/2024*

Implemented [redacted] - 10/21/2024)

16c - Written Incident Report

3. Requirements

2600.

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

16c - Written Incident Report *(continued)*

Description of Violation

On at the afternoon shift-change, Direct Care Staff Member A was assisting Resident #3 in the bathroom but left him/her in the bathroom when Staff Member A's shift ended at . Oncoming staff discovered Resident #3 in the bathroom, alone, covered in bowel movement. The resident's support plan, dated , states that the resident needs total physical assistance with toileting which was not provided on The home did not report this incident to the Department.

Repeated Violation - 12/12/23, et al.

Plan of Correction ***Accept 08/06/2024)***

Beginning 7/3/24, the Administrator/designee shall report allegations of abuse or neglect to the Departments of Human Services as required by regulation 16.c.

The Administrator reported the allegation of neglect in accordance with Regulation 16.c. on 7/3/24. The Administrator/designee shall re-educate current associates on incident reporting by 8/2/24. Documentation shall be kept.

Beginning 7/3/24 and ongoing, the Administrator/designee shall review all resident incidents on or before the next business day after occurrence to ensure that any that meet the requirements in Regulation 2600.16.c are reported to the Department as required.

Beginning 7/25/24, adherence to 2600.16c, Written Incident Report, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented - 10/21/2024)

42b - Abuse

4. 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

On at the afternoon shift-change, Direct Care Staff Member A was assisting Resident #3 in the bathroom but left him/her in the bathroom when Staff Member A's shift ended at 3 PM. Oncoming staff discovered Resident #3 in the bathroom, alone, covered in bowel movement. The resident's support plan, dated , states that the resident needs total physical assistance with toileting which was not provided on

Repeated Violation - 12/12/32, et al.

42b - Abuse *(continued)*

Plan of Correction ***Accept (08/06/2024)***

On the oncoming associate assisted the resident to ensure they received proper care.

Following the serious allegations of neglect identified during the 7/2/24 and 7/3/24 inspections, Staff Member A was removed from direct care and reassigned as a server. This reassignment comes with the condition of being under direct supervision at all times, highlighting the gravity of the situation.

The Administrator/designee shall conduct a re-education session for current staff on the definition of abuse and neglect, prevention, and how it relates to residents' rights, duties, and responsibilities as caregivers by 8/2/24. This re-education is a crucial step in reinforcing our commitment to resident safety and staff compliance by providing care to residents by reviewing resident assessment and support plans before providing services, so residents' needs are being met in a safe manner. Documentation shall be kept.

Effective immediately, 7/25/24, and as part of our ongoing commitment to staff development and resident safety, all staff will receive training on preventing abuse and neglect upon hire, annually, or as needed. This continuous training, provided through Relias and/or face-to-face sessions led by the Administrator, Customer Service Associate, or Healthcare Director, ensures that staff are always equipped with the necessary skills to provide the best care. Documentation shall be kept.

Beginning 7/25/24, adherence to 2600.42b, Abuse, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. These meetings are about compliance and ensuring the safety and well-being of our residents and staff. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented (- 10/21/2024)

51 - Criminal Background Check

5. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff Member B, hired on does not have a Pennsylvania criminal history background check.

Plan of Correction ***Accept (- 08/06/2024)***

The Customer Service Associate completed a Pennsylvania criminal history background check for Staff Member B on

Beginning and ongoing, the Customer Service Associate/designee shall complete criminal history background checks for all new associates per Regulation 2600.51, Criminal Background Check.

On 7/15/24 and 7/26/24, the Administrator and designee re-educated the Customer Service Associate on the criminal history checks and hiring policies outlined in Regulation 2600.51.

The Customer Service Associate audited all staff files before 7/25/24 to ensure all staff had a criminal history

51 - Criminal Background Check (continued)

background check on file. No additional deficiencies were noted. Documentation shall be kept.

Beginning 7/25/24, The Administrator/designee shall review all completed new hire files monthly to ensure that the criminal history background check was completed during monthly scheduled Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented (- 10/21/2024)

65a - FS Orientation 1st Day

6. 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

At the time of the 7/2/24 inspection, Staff Member C, began working in the home around , and has not received 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 (- 08/06/2024)***

Staff Member C was an employee of a staffing agency. This agency staff member no longer provides services to the community.

On 7/15/24 and 7/26/24, the Maintenance Director and Customer Service Associate received re-education from the Administrator and designee on the required fire safety training that all associates must complete on their first day of work.

The Customer Service Associate audited all staff files by 7/25/24 to ensure that all staff had received fire safety training. No additional deficiencies were noted. Documentation shall be kept.

65a FS Orientation 1st Day (continued)

Beginning 7/5/24 and continuing, the Maintenance Director/designee will conduct the Fire Safety orientation training with all new staff and agency or contracted labor on their first day of work. This ongoing training ensures that everyone is well prepared for any fire safety situation.

Beginning 7/5/24 and continuing, the Customer Service Associate or designee shall review all completed new hire files upon hire to ensure the Maintenance Director completes the Fire Safety Training on their first day of work.

Beginning 7/25/24, compliance monitoring on adherence to 2600.65a, FS Orientation, will be conducted during regularly scheduled monthly Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented (- 10/21/2024)

82c - Locking Poisonous Materials

7. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On at approximately , Oasis 137 Orange Force with a manufacture's label indicating "do not drink" and "get medical attention if you feel unwell," was unlocked, unattended, and accessible to residents in the unlocked kitchenette in the Secured Dementia Care Unit. All but one resident in the SDCU have been assessed as incapable of recognizing and using poisons safely.

Repeated Violation 12/12/23, et al.

Plan of Correction ***Accept - 08/06/2024)***

The Oasis 137 Orange Force was removed from the SDCU kitchenette by the Maintenance Director on 7/2/24.

The Maintenance Director audited the SDCU on 7/3/24 to ensure no other unsecured poisonous materials or cleaning products were present.

Beginning 7/19/24, housekeeping staff will utilize a new checklist for their daily cleaning routine, which was updated by the Administrator on 7/18/24 to include monitoring the SDCU for secure poisonous material storage.

By 8/2/24, the Maintenance Director/designee will re educate all current employees on Regulation 82.c, Locking Poisonous Materials, on properly storing and securing any items labeled poisonous or hazardous. Documentation shall be kept.

Beginning 7/25/24, adherence to 2600.82c, Locking Poisonous Materials, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/03/2024*

82c Locking Poisonous Materials *(continued)*

Implemented (- 10/21/2024)

85a Sanitary Conditions

8. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On at approximately , multiple red and brown blood stains were on Resident #5's bedroom carpet, covering approximately 4'X2' area next to their bed and leading into their bathroom. In addition, there were multiple dark red and bright red stains, again appearing to be blood, on the resident's towel hanging in the bathroom. Three spots, approximately the size of fingerprints, of red matter were stained onto Resident #5's bathroom wall, above the handrail next to the toilet.

Plan of Correction ***Accept (- 07/30/2024)***

The Maintenance Director and Housekeeping team cleaned Resident #5's bedroom on 7/3/24.

The Maintenance Director audited all resident rooms on 7/5/24 to ensure compliance with 2600.85a Sanitary Conditions. Documentation shall be kept.

Beginning 7/15/24, the weekly housekeeping cleaning schedule has been updated to include documentation of room cleaning by housekeeping for every room they clean.

By 8/2/24, the Maintenance Director/designee will re-educate current associates on where to access cleaning products for quick clean-ups and when and how to report in-depth cleaning and maintenance needs to the maintenance department. Documentation shall be kept.

Adherence to 2600.85a, Sanitary Conditions, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented - 10/21/2024)

85e Trash Outside Home

9. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/2/24, at approximately 10:45 AM, the sliding door on the exterior dumpster was open and the dumpster was full of trash. Additionally, there was trash gathered on the ground around the dumpster which was not actively in use at the time of the observation.

85e - Trash Outside Home *(continued)*

Plan of Correction ***Accept (- 07/30/2024)***

The Dining Director closed the dumpster lid on 7/2/24.

Beginning 7/3/24, the Maintenance Director will randomly audit the dumpsters weekly to ensure the lids/doors are closed.

On 7/3/24, the Administrator placed "Please Close the Dumpster Door" signs on both dumpsters and the door leading to the dumpsters.

The Maintenance Director/designee will re-educate current associates on Regulation 2600.85e, Trash Outside Home, by 8/2/24, ensuring the dumpster lid is closed when not in use.

Adherence to 2600.85e, Trash Outside Home, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented (10/21/2024)

89b - Hot Water Temperature

10. Requirements

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

The water temperature in the home exceeded 120 degrees Fahrenheit in multiple locations, including:

- *On 7/2/24, the laundry room across from resident room A106 at 10:10 AM measured 125.5.*
- *On 7/2/24, the bistro sink at 10:15 AM measured 123.5.*
- *On 7/2/24, the sink in the theater room at 10:18 AM measured 124.5.*
- *On 7/3/24, the water at the bathroom sink in bedroom A132 at 11:45 AM measured 127.*

Plan of Correction ***Accept (- 08/06/2024)***

The Maintenance Director called the contracted plumbing company on 7/3/24, and they were on site on 7/5/24. They determined that a hot water mixing valve was malfunctioning. This repair was vital as it directly impacted the system's functionality. They ordered a replacement valve, and the repair was fixed on 7/18/24.

By 7/31/2024, the Administrator/designee shall re-educate the Maintenance Director on hot water temperature limits and the required water temperature checks, including making prompt adjustments and reporting out-of-range temperatures to the Administrator.

Beginning 8/1/24, the Maintenance Director will diligently conduct weekly hot water temperature checks for 30 days and then continue with monthly checks. This regular and consistent monitoring is a crucial task that ensures the resident-accessible hot water temperature is maintained at approximately 120°F, a critical factor in our system's

89b - Hot Water Temperature (continued)

functionality. The Maintenance Director will promptly make adjustments if the hot water temperature is out of the required range, and comprehensive documentation of these checks will be maintained for reference. Documentation shall be kept.

Beginning 7/25/24, adherence to 2600.89b, Hot Water Temperature, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. These meetings, which play a pivotal role in ensuring compliance with regulations and the safety of our residents, will be comprehensive, and their documentation will be maintained for reference.

Licensee's Proposed Overall Completion Date: *09/02/2024*

Implemented (- 10/21/2024)

103f - Refrigerator/Freezer Temps

11. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 7/2/24 at approximately 10:18 AM, the freezer in the theater room was not equipped with a thermometer.

Plan of Correction ***Accept (- 07/30/2024)***

The Administrator purchased new thermometers on 7/2/24, and the Maintenance Director placed one in the movie theatre room freezer on 7/3/24.

Beginning 7/3/24, the Dining Director/designee shall check all refrigerators and freezers for working thermometers and required temperatures daily for 30 days. Documentation shall be kept.

On 7/26/24, the Dining Director re-educated the current Life Enrichment staff on Regulation 2600.103f, refrigerator/freezer temperatures, and the requirements for monitoring proper temperature and missing or broken thermometers. Documentation shall be kept.

Adherence to 2600.103f, Refrigerator/Freezer Temps, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented 10/21/2024)

103g - Storing Food

12. Requirements

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

103g Storing Food *(continued)*

Description of Violation

On 7/2/24 at approximately 10:13 AM, approximately 15 baked cookies were uncovered on a plate in the bistro.

On 7/2/24 at approximately 10:18 AM, there was a box of already made cookies stored in the freezer in an open and unsealed bag, inside an open and unsealed box.

On 7/3/24, there were three plastic containers in the walk in cooler that were not sealed including:
- *A container labeled noodles dated 7/3 with a red lid that did not fit.*
- *A container labeled vegetables dated 7/3 with a lid that wasn't closed.*
- *A container labeled soup and dated 7/1 with a lid that did not fit.*

Repeated Violation 2/6/24, 12/12/23, et al.

Plan of Correction ***Accept (- 07/30/2024)***

The food items identified on the LIS were discarded immediately upon discovery. The Dining Director ordered new containers with lids for proper food storage, which were received on 7/18/24.

The Dining Director will re educate dining staff on Regulation 103g, Storing Food, properly covering all food items by 8/2/24.

Beginning 7/30/24, the Dining Director/designee shall audit the bistro and kitchen weekly for 30 days to ensure food is appropriately covered, labeled, and dated. Bistro and Kitchen audits check audits shall be kept.

Adherence to 2600.103g, Storing Food, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

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

Implemented (- 10/21/2024)

107d - Procedure Emergency Management Agency Submission

13. 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 have not been sent to the local emergency management agency since 5/18/22.

Plan of Correction ***Accept (- 08/06/2024)***

The Communities' Emergency Plan was reviewed and submitted by the Administrator to the local EMA on 7/15/24.

On 8/6/24, the Regional Director of Operations shall re educate the Administrator on regulation 107d and the annual review, updates and EMA submission requirement.

107d - Procedure Emergency Management Agency Submission (continued)

The Administrator placed a copy of the review and correspondence in the Emergency Preparedness Binder on 7/15/24.

The Administrator created a calendar task to review, update, and submit the emergency plan by 7/1/25.

Licensee's Proposed Overall Completion Date: *08/07/2024*

Implemented (- 10/21/2024)

132c - Fire Drill Records

14. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill records for the drills conducted on 12/28/23, 1/30/24, 2/28/24, 3/26/24, and 4/27/24, do not include the exit route used, any problems encountered during the drill, planned corrective actions, and on two occasions (4/27/24 and 1/30/24) do not include AM or PM for the time of the drill.

Plan of Correction ***Accept (- 07/30/2024)***

The home identified this documentation error during a mock inspection from 5/6 to 5/7/24 and began using the Department's model fire drill record form on 5/7/24.

On 7/15/24, the Administrator/designee re-educated the Maintenance Director on properly documenting fire drills on the fire drill record form. The Maintenance Director's commitment to ongoing training was evident when they attended the Fire Safety Train the Trainer on 7/25/24 with Fire Safety Solutions. This continuous training ensures that our fire safety procedures are always up-to-date and effective. Documentation shall be kept.

Beginning 7/31/24, the Administrator/designee shall review the fire drill record monthly to ensure that all required information, such as exit routes and drill time, is accurately captured. Compliance monitoring on adherence to 2600.132c, Fire Drill Records, will be conducted during regularly scheduled Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented (- 10/21/2024)

132d - Evacuation

15. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

132d - Evacuation *(continued)*

Description of Violation

The home did not evacuate all residents to a fire safe area or the exterior of the building during the following fire drills:

- *12/28/23, 63 residents in the home at the time of the drill and only 12 evacuated.*
- *1/30/24, 70 residents in the home at the time of the drill and only 11 evacuated.*
- *2/28/24, 69 residents in the home at the time of the drill and only 8 evacuated.*
- *3/26/24, 69 residents in the home at the time of the drill and only 11 evacuated.*
- *4/27/24, 66 residents in the home at the time of the drill and only 23 evacuated.*
- *5/30/24, 69 residents in the home at the time of the drill and only 16 evacuated.*
- *6/28/24, 69 residents in the home at the time of the drill and only 10 evacuated.*

Plan of Correction ***Accept (- 08/06/2024)***

Beginning 7/3/24, during monthly fire drills, the Maintenance Director will ensure all residents are safely evacuated and document all residents as evacuated, not just those who had to physically move from the area of the mock fire to a fire-safe area.

On 7/15/24, the Administrator re-educated the Maintenance Director on properly documenting evacuations. The Maintenance Director's commitment to ongoing training was evident when they attended the Fire Safety Train the Trainer on 7/25/24 with Fire Safety Solutions. This continuous training ensures that our fire safety procedures are always up-to-date and effective. Documentation shall be kept.

By 8/5/24, the Administrator/designee shall send correspondence to all residents stating that they must participate during a fire drill, even if their apartment is located in a fire-safe area.

By 8/9/24, the Maintenance Director/designee shall re-educate all current staff on fire drill requirements, including, but not limited to, notifying the residents of the mock fire's location and ensuring that residents who are already in fire-safe areas are up and at their doors ready to evacuate.

Beginning 7/25/24, the Administrator/designee shall review the fire drill record monthly to ensure that all required information is accurately captured. Compliance monitoring on adherence to 2600.132d, Evacuation, will be conducted during regularly scheduled monthly Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/10/2024*

Implemented (- 10/21/2024)

132e - Fire Drill Sleeping Hours

16. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

At the time of the 7/2/24 inspection, the last fire drill conducted during sleeping hours was on .

132e - Fire Drill Sleeping Hours (continued)

Plan of Correction ***Accept (█ - 07/30/2024)***

An overnight fire drill was conducted on 4/29/24; however, the 3rd shift and the time without am or pm were written on the fire drill record.

On 7/15/24, the Administrator re-educated the Maintenance Director on properly documenting fire drills on the Department's model fire drill record form. Documentation shall be retained. The Maintenance Director's commitment to ongoing training was evident when they attended the Fire Safety Train the Trainer on 7/25/24 with Fire Safety Solutions. This continuous training ensures that our fire safety procedures are always up-to-date and effective. Documentation shall be kept.

Beginning 7/31/24, The Administrator/designee shall review the fire drill record monthly without fail, instilling a sense of routine and discipline to ensure that an overnight drill was accurately documented and that a pending 6-month overnight drill is not missed. Compliance monitoring on adherence to 2600.132e, Fire Drill Sleeping Hours, will be conducted during regularly scheduled Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented (█ - 10/21/2024)

162c - Menus Posted

17. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

At the time of the 7/2/24 inspection, the home's menu for the current week was posted. However, the menu for one week in advance, July 7th-13th, 2024, was not posted.

Plan of Correction ***Accept (█ - 07/30/2024)***

The Dining Director printed and posted the July 7th -13th menu on 7/2/24.

Beginning 7/7/24, The Dining Director/designee will check the menus weekly to ensure the current two weeks' menus are always posted.

The Administrator will re-educate the Dining Director on Regulation 2600.162c, Menus Posted, specifically on the importance of posting a 2-week menu for residents by 7/25/24. The Dining Director will train a designee to serve as a backup to print and post menus in the absence of the Dining Director by 7/31/24. Documentation shall be kept.

Adherence to 2600.162c, Menus Posted, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

162c - Menus Posted *(continued)*

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented ██ - 10/21/2024)

162e - Menu Changes

18. Requirements

2600.
162.e. A change to a menu shall be posted in a conspicuous and public place in the home and shall be accessible to a resident in advance of the meal. Meal substitutions shall be made in accordance with § 2600.161 (relating to nutritional adequacy).

Description of Violation

On 7/2/24, marinated flank steak or roasted chicken with lemon thyme sauce was listed on the menu for the 7/2/24 lunch meal. However, chicken teriyaki or beef tips were being served as the entree. A notice was not provided to the residents in advance of the meal.

Plan of Correction ***Accept ██ - 07/30/2024)***

Beginning 7/3/24, the Dining Director/designee shall ensure all menu changes are posted before mealtime.

The Administrator will review the menu change process and re-educate the Dining Director on posting all changes before meals by 7/25/24.

Beginning 7/30/24, the Administrator/designee shall complete a random audit of resident meals once a week for 30 days to ensure that what is served is what is on the menu and that, if not, the change has been posted. Variances shall be corrected immediately.

Adherence to 2600.162e, Menu Changes, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

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

Implemented (██ - 10/21/2024)

171b5 - First Aid Kit

19. 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

At the time of the 7/2/24 inspection, the first aid kits in the Ford E350 bus and Buick sedan were each missing a thermometer, eye coverings, and breathing shield.

Repeated Violation - 12/12/23, et al.

171b5 - First Aid Kit *(continued)*

Plan of Correction ***Accept (07/30/2024)***

The Administrator ordered a thermometer, eye coverings, and a breathing shield on 7/7/24 and added them to the Ford E350 bus and Buick sedan on 7/9/24.

The Administrator will re-educate all staff who drive the vehicles on the required contents of the first aid kit per Regulation 2600.171b5, First Aid Kit, by 7/31/24.

Beginning 8/1/24, the Maintenance Director/designee shall inspect both vehicles' first aid kits monthly to ensure that the required items are present. Missing items shall be replaced immediately, and documentation shall be kept.

Compliance monitoring on adherence to 2600.171b5, First Aid Kit, will be conducted during regularly scheduled Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/01/2024*

Implemented - 10/21/2024)

171c - Home's Vehicle Documents

20. Requirements

2600.

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

4. Current inspection.

Description of Violation

On 7/2/24, the home's Ford E350 bus was used to transport Resident #6 home from a medical appointment. The vehicle is not currently inspected; the inspection certificate expired on 6/30/2024.

Plan of Correction ***Accept (- 08/06/2024)***

The Ford E350 was inspected on 7/5/24.

On 7/5/24, the Administrator created a tickler file and calendar task to indicate when the vehicle registration, insurance, and inspection are due.

On 8/6/24, the Regional Director of Operations shall re-educate the Administrator and Maintenance Director on Regulation 2600.171c, Home's Vehicle Documents.

Beginning 7/26/24, The Maintenance Director shall walk around the community's vehicles monthly to ensure that the registration and inspection are current. Documentation shall be kept.

Beginning 7/25/24, compliance monitoring on adherence to 2600.171c, Home's Vehicle Documents, will be conducted during regularly scheduled monthly Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/07/2024*

Implemented - 10/21/2024)

182c - Medication Administration

21. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On 7/3/24 at 11:45 AM, Staff Member D handed Resident #5 a cup of multiple medications and failed to observe the resident consuming the medications. Per Resident #5's medication administration record (mar), the medications in the cup included: Amlodipine Besylate 10 mg tablet, Diltiazem 24h ER 360 mg CP, Folic Acid 1 mg tablet, Lisinopril 10 mg tab, Preservision AREDS 2, Vitamin B-1 100 mg tab, and Vitamin B-12 1,000 MCG Tab. According to Resident #5's current, 1/8/24 medical evaluation, they cannot self-administer medications.

Plan of Correction ***Accept [redacted] - 07/30/2024)***

On 7/24/24, Staff Member D was re-educated by the home's medication trainer on Regulation 2600.182c, Medication Administration.

By 7/25/24, The Health Care Director or designee shall re-educate all med techs on medication administration practices, including observing residents physically take their medication, included in Regulation 2600.182c.

Beginning 7/29/24, the Healthcare Director/designee shall observe a random medication pass once a week for 30 days to ensure that staff follow proper medication administration protocols.

Adherence to 2600.182c, Medication Administration, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

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

Not Implemented ([redacted] 10/21/2024)

183b - Meds and Syringes Locked

22. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted], Resident #4 reported they do not lock their bedroom door and do not have a key to lock their bedroom door when they leave their room for meals and activities. Upon inspection of Resident #4's bedroom, the nightstand next to their bed contained 3 drawers full of medication blister packs, and two medication blister packs on the nightstand. The nightstand did not contain a locking mechanism. Medications unlocked, accessible, and unattended in/on the nightstand included: [redacted]

On [redacted], a small, round, pinkish pill was unlocked, unattended, and accessible lying on Resident #5's

183b Meds and Syringes Locked (continued)

living room floor. In addition, there is a [redacted] on the end table in their living room. Resident #5 is not assessed to self administer their medications.

Plan of Correction ***Accept [redacted] - 08/06/2024)***

Beginning 7/3/24 and continuing, the Physician and the Healthcare Director shall adequately assess any new admission who wants to administer medication, and the home shall approve measures to keep medication secure before service.

On 7/4/24, Resident #4 was assessed by the Healthcare Director as not capable of self administering medications, and the home took over medication administration.

On 7/4/24, the Healthcare Director received a physician's order for Resident #5 to self administer their Respimat inhaler.

By 7/31/24, The Healthcare Director/designee shall inspect every room of the residents who self administer medication to ensure they have a mechanism to secure their medication and adhere to Regulation 2600.183b when not in their room.

By 7/31/24, The Healthcare Director/designee will reassess all residents who self administer medication to ensure that they can self administer medication and review the requirement of securely storing it when they are out of their room. Documentation shall be kept.

By 8/9/24, the Health Care Director or designee shall re educate current staff on the requirement for medications to be kept in the resident's room in a locked area or the home's medication cart based on the resident's assessment and support plan.

By 8/9/24, the Health Care Director or designees shall inspect all resident rooms to ensure that all medication is securely stored. Any medication not securely stored shall be immediately secured or removed from the resident's room and secured in the medication cart.

By 8/9/24, the Administrator/designee shall send correspondence to all residents stating that all medications must be kept in a locked area or container.

Beginning 7/29/24, the Healthcare Director/designee shall complete a random audit of the rooms of the residents who self administer medication weekly for 30 days to ensure compliance with securing medication. Documentation shall be kept.

Beginning 7/25/24, adherence to 2600.183b, Meds and Syringes Locked, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents, reinforcing our commitment to their well being. Comprehensive documentation of these meetings will be maintained for reference.

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

Not Implemented ([redacted] - 10/21/2024)

183e - Storing Medications

23. 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 at approximately Resident #10's pill was popped out of the blister pack, placed back in the blister pack, and held in by a piece of tape covering the back of the blister pack.

Repeated Violation - 12/12/23, et al., 10/4/23, et al.

Plan of Correction ***Accept - 07/30/2024)***

The identified medication was removed from the blister pack on by the Healthcare Director and adequately disposed of.

The Healthcare Director/designee performed a complete med cart audit on 7/25/24 and removed any medications that were put back into blister packs and taped to hold the pill in place. No additional deficiencies were identified.

The Healthcare Director/designee re-educated all med techs on medication administration practices, expressly, but not limited to, properly disposing of medications removed from packaging, fallen out of the packaging, or refused by the resident on 7/24/24.

Beginning 7/29/24, the Healthcare Director/designee shall perform weekly med cart audits for 30 days to ensure that medications pulled from their container but not administered are appropriately disposed of to avoid potential medication errors.

Adherence to 2600.183e, Storing Medications, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

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

Not Implemented (- 10/21/2024)

185a Implement Storage Procedures

24. 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

Resident #1 is prescribed , insert 1 suppository per rectum every 2 days as needed if no bowel movement. Per staff interview, the home is not documenting or tracking the resident's bowel movements to know when to administer the as needed . At the time of the 7/3/24 inspection, staff could not locate any record for Resident #1's documenting the resident had a bowel movement in the previous 5 days, or that was administered as prescribed in the previous 5 days.

185a - Implement Storage Procedures (continued)

Resident #8 is prescribed [redacted], take 2 puffs by mouth every 6 hours as needed for [redacted] This medication is not present the home.

The glucometer for Resident #7 is not dated and timed correctly, reading [redacted] when the time was [redacted]

Multiple blood sugar readings appear on Resident #7's mar that are not stored in the resident's meter including:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Repeated Violation - 2/6/24, 12/12/23, et al.

Plan of Correction ***Accept [redacted] - 08/06/2024)***

The Healthcare Director completed the following corrections to the residents' medications and orders that were identified during the inspection.

Resident #1: On [redacted] the Healthcare Director obtained an order to discontinue the prescription for the [redacted] due to non-use.

Resident #5: The Administrator purchased [redacted], and the Healthcare Director validated that they were available in the home on [redacted]

Resident #8: The Healthcare Director ordered and validated that the [redacted] inhaler was in the home on [redacted]

Resident #7: The Healthcare Director recalibrated the glucometer on [redacted]

By 7/25/24, The Healthcare Director/designee re-educated all med techs on the proper use of medical equipment, such as glucometer use, correctly transcribing blood glucose levels from the glucometer to the Medication Administration Record, prescription order monitoring, and timely medication re-ordering. Documentation of training shall be kept.

Beginning 7/22/24, the Healthcare Director/designee shall conduct an initial audit of every medication cart to

185a - Implement Storage Procedures (continued)

ensure medications are current and available as ordered. The day following the completion of initial medication cart audits, the Healthcare Director/designee shall audit them daily for five days and then weekly for 30 days to ensure that the glucometer dates, times, and readings are accurate and match the numbers recorded in the MAR. Documentation of the audits shall be kept.

Beginning 8/1/2024, all Medication Administration Associates will be responsible for checking their assigned medication carts daily to ensure that medications are available and will be responsible for faxing the physician and/or pharmacy for refills before the current order runs out.

Beginning 7/25/24, adherence to 2600.185a, Implement Storage Procedures, will be rigorously monitored during our regularly scheduled monthly Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

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

Not Implemented - 10/21/2024)

187a - Medication Record

25. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1's June and July 2024, medication administration records (mar) do not include the diagnosis or reason for prescribing their daily and as needed .

Resident #7 is prescribed sliding scale insulin; however, the home does not record the dose of insulin administered on the resident's mar.

Plan of Correction ***Accept - 07/30/2024)***

The MAR for resident #1 was corrected during the inspection to include the information identified in the violation.

On 7/25/24, the Healthcare Director re-educated current med techs on the required information and ensured they reviewed the MARs for missing information for new orders and routine med passes.

By 8/1/24, The Healthcare Director/designee will have reviewed the MARS for all residents to ensure they contain the information required by regulation 2600.187a, Medication Record.

Beginning 8/2/24, the Healthcare Director or designee shall audit the MARs weekly for 30 days and then monthly to ensure that the required information is present and accurate.

Adherence to 2600.183e, Medication Record, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

187a - Medication Record (continued)

Proposed Overall Completion Date: 09/01/2024

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

Not Implemented (- 10/21/2024)

225a - Assessment 15 Days

26. Requirements

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

Description of Violation

Resident #4's assessment does not indicate their need for the enabler bar on his/her bed.

Resident #1's assessment reads, the resident is moderately immobile. However, per staff interview and Resident #1's medical evaluation, the resident is totally immobile and requires a wheelchair at all times to ambulate.

Plan of Correction ***Accept - 08/06/2024)***

On , the Healthcare Director amended Resident #1's RASP to capture the resident's bed and other mobility needs correctly. The Maintenance Director removed resident #4's enabler bar on as requested by the resident; no revision to the RASP was needed.

By , the Regional Healthcare Specialist shall re-educate the Healthcare Director/designee on what needs must be covered in the RASPs and proper RASP completion as a new Healthcare Director was hired on

By 8/2/24, the Healthcare Director/designee will review the resident RASPs of all residents who use an enabler bar or are deemed immobile to ensure that the service need and delivery are accurately captured. Corrections will be made, and documentation of the RASPs reviewed will be kept.

Beginning 8/1/24, the Healthcare Director/designee will assess any resident who requests an enabler bar for need and ability to use. The resident and/or responsible party will be notified of the FDA spacing and/or covering and attachment requirements before the device is purchased and/or installed for use. Once installed, the resident's assessment and support plan will be immediately updated.

Beginning 8/1/24, the Healthcare Director/designee and the Assistant Health Care Director/designee will review all new assessments once per week and immediately correct non-compliance to ensure ongoing compliance with Regulation 2600.225a, including, but not limited to, mobility.

Beginning 7/25/24, adherence to 2600.225a, Assessment 15 Days, will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

225a - Assessment 15 Days *(continued)*

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented (- 10/21/2024)

225c - Additional Assessment

27. Requirements

2600.
225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #1's current assessment was completed on , and their previous assessment was completed on However, the resident's dietary needs changed on to include chopped food, chopped meats, and encouraging hydration with frequent drinks. Additionally, on the resident was ordered twice daily and finger foods as the staff was noticing the residents is only eating very soft foods and will not eat anything they have to chew. At the time of the 7/2/24 inspection, Resident #1's assessment and support plans were never updated to include these dietary changes and physician's orders.

Resident #8's current assessment was completed on . However, the resident's previous assessment was completed on

Resident #11's current assessment was completed on . However, the resident's previous assessment was completed on

Plan of Correction ***Accept - 08/06/2024)***

On 7/3/24, the Healthcare Director updated Resident #1, RASP, to include their dietary changes.

The Healthcare Director/designee shall review all RASPs by 8/15/24 to ensure they have been completed annually or adequately updated to include recent changes in orders or services. The Healthcare Director/designee shall correct any RASPs out of compliance by 8/31/24.

By 8/9/24, the Healthcare Director/designee shall re-educate current staff on their responsibility to notify the Healthcare Director or Assistant Healthcare Director of any resident change in condition so any needed updates to their assessment and support plan can be made promptly.

Beginning 7/25/24. adherence to 2600.225c, Additional Assessment, resident change in condition and completion of additional assessments will be reviewed with the Administrator by the Health Care Director or designee as they occur, and their ongoing progress will be rigorously monitored during our regularly scheduled Quality Assurance meetings. This is a critical step in ensuring compliance with regulations and the safety of our residents. Comprehensive documentation of these meetings will be maintained for reference.

Proposed Overall Completion Date: 08/10/2024

Licensee's Proposed Overall Completion Date: *08/10/2024*

Implemented (- 10/21/2024)

233c - Key-Locking Devices

28. 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

The directions for operating the home's locking mechanism for the interior and exterior doors to the Secure Dementia Care Unit (SDCU) do not allow for immediate egress. The different codes for both interior and exterior doors could not be determined without assistance from a home's staff.
Repeat violation: 10/4/2023

Plan of Correction ***Accept (08/06/2024)***

On 7/22/24, The Administrator/designee created and posted a new sign to make it easier for individuals without dementia to enter and exit the neighborhood.

By 8/1/24, the Administrator or designee shall re-educate the Maintenance Director and all other staff who have access to change the SDCU magnetic locking system codes on ensuring that the disguised directions are posted at all points of ingress/egress in a manner that permits staff persons and visitors to obtain immediate egress on their own and at will without having to ask for assistance.

Beginning 7/29/24, The Maintenance Director/designee shall check the posting weekly for 30 days to ensure they remain posted and easily viewable.

The Maintenance Director/designee shall change the code and place new signage should any resident determine the code with the newly posted format.

Compliance monitoring on adherence to 2600.233c, Key-Locking Devices, will be conducted during regularly scheduled Quality Assurance meetings. Documentation shall be kept.

Licensee's Proposed Overall Completion Date: *08/03/2024*

Implemented - 10/21/2024)

252 - Record Content

29. 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.
4. Language or means of communication spoken or used by the resident.

Description of Violation

Resident #1's and #8's records do not include their religion or language.

Plan of Correction ***Accept - 07/30/2024)***

On 7/23/24, the Healthcare Director updated Resident #1 and Resident #8's records to include the missing information.

252 - Record Content (continued)

The Regional Healthcare Specialist shall re-educate the Healthcare Director/designee on the requirement of this regulation by 7/31/24.

The Healthcare Director/designee shall audit and correct all resident records by 8/15/24 to ensure they contain the required information under Regulation 2600.252, Record Content.

Beginning 7/29/24 and ongoing, the Administrator, Healthcare Director, or designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.252, Record Content. Ongoing compliance will be maintained, and documentation will be retained.

Licensee's Proposed Overall Completion Date: *08/15/2024*

Implemented ██ - 10/21/2024)

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LITITZ* **License #**: *33298* **License Expiration**: *09/18/2024*

Address: *80 WEST MILLPORT ROAD, LITITZ, PA 17543*

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

Administrator

Name:

Legal Entity

Name: *LITITZ PCH LLC*
Address: *80 WEST MILLPORT ROAD, LITITZ, PA, 17543*
Phone:

Certificate(s) of Occupancy

Type: *I 1* **Date**: *11/08/2016* **Issued By**: *Warwick Township*
Type: *I 2* **Date**: *11/08/2016* **Issued By**: *Warwick Township*
Type: *Other* **Date**: *11/08/2016* **Issued By**: *Warwick Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *107* **Waking Staff**: *80*

Inspection Information

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

Reason: *Incident, Interim* **Exit Conference Date**: *09/20/2024*

Inspection Dates and Department Representative

09/19/2024 On Site:
09/20/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *78*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *40* **Residents Served**: *24*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *78*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *29* **Have Physical Disability**: *0*

Inspections / Reviews

09/19/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/11/2024*

10/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/14/2024*

10/08/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/21/2024*

10/21/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *10/18/2024*

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 , medication cart 2 was unattended in the back hallway. A piece of paper on top of the cart listed various resident names and included the names of medications prescribed for them or directions for administration including:

- Resident 1,
- Resident 2,
- Resident 3,
- Resident 4, ' "

On , a binder was unlocked, unattended, and accessible on the side of one of the medication carts outside of the dining room. The binder was labeled, "Medication return log book" and contained the names of medications and the residents to whom they were prescribed including:

Resident 5,
Resident 6,
Resident 7,

Plan of Correction ***Accept - 10/08/2024)***

The confidential resident information was immediately placed in a secure confidential area by the nurse on duty at time of survey on 9/19/24.

All common areas audited on day of survey 9/19/24 by Health Care Director for compliance with regulation 2600.17.

Staff shall be educated on regulation 2600.17 by Health Care Director by 10/11/24.

Beginning 10/7/24, Health Care director or designee will randomly audit medication carts and common areas for confidential resident information 3 times per week X 4 weeks, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.17.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Implemented - 10/21/2024)

183b Meds and Syringes Locked

2. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On [redacted] at approximately [redacted], there were full pill containers and a cup containing a white oval pill and a round peach pill medications prescribed for Resident 10 that were unlocked, unattended, and accessible in the resident's room.

On [redacted] there were medications prescribed for Resident 11 that were unlocked, unattended, and accessible in the resident's bedroom. Resident 12 who also resides in the room is not assessed to self-administer. Medications included a bottle of [redacted], a bottle of [redacted] tablets, and a tube of [redacted].

Plan of Correction ***Accept ([redacted] 10/08/2024)***

The unattended medications in Resident 10, 11 and 12's rooms were immediately removed by Health Care Director at time of survey on 9/19/24.

Audit of all resident rooms completed by the Health Care Director on 10/4/24 to ensure compliance with regulation 183b.

Staff shall be educated on regulation 2600.183b by Health Care Director by 10/11/24. Residents shall be educated on regulation 2600.183b at resident council by Residence Director on 10/16/24. Family members educated on regulation 183b via family letter by Residence Director on 10/4/24.

Beginning 10/7/24, Health Care Director or designee will randomly audit 5 resident rooms for compliance with regulation 183b 3 times per week X 4 weeks, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 183b.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented ([redacted] - 10/21/2024)

183e Storing Medications

3. 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.

183e Storing Medications *(continued)*

Description of Violation

On 9/19/24 at 2:15 PM, there was an oval tablet observed on the floor of the medication room. Inside medication cart 1, there was a small, round tablet observed loose in one of the drawers.

Repeated Violation 12/12/23, et al., 10/4/23, et al.

Plan of Correction ***Accept (- 10/08/2024)***

Loose pills removed and discarded by Health Care Director at time of survey on 9/19/24.

Remaining areas of medication carts audited for compliance with regulation 2600.183e by Health Care Director at time of survey on 9/19/24.

Health and Wellness staff shall be educated on regulation 2600.183e by Health Care Director by 10/11/24.

Beginning 10/7/24, Health Care Director or designee will audit medication carts and medication room for compliance with regulation 2600.183e 3 times per week X 4 weeks, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.183e.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented (- 10/21/2024)

184a - Resident's Meds Labeled

4. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident 3 is prescribed insulin based on a sliding scale. The sliding scale documented on the medication administration record (MAR) is different from that on the pharmacy bag in which the insulin pen is stored. The MAR shows coverage starting at .

Plan of Correction ***Accept (- 10/08/2024)***

At time of survey 9/19/24, physician contacted by Health Care Director to clarify sliding scale order, order discontinued for sliding scale due to non use.

Audit of medication carts to ensure compliance with regulation 2600.184a completed by Health Care Director on

184a - Resident's Meds Labeled (continued)

9/19/24, no further issues noted.

Health and Wellness staff who administer medications shall be educated on regulation 2600.184a by Health Care Director by 10/11/24.

Beginning 10/7/24, Health Care Director or designee will audit medication carts for compliance with regulation 2600.184a weekly X 4 weeks, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.184a.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented (- 10/21/2024)

185a - Implement Storage Procedures

5. 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

Resident 3 gets blood sugar checks three times daily along with insulin administered according to a sliding scale. There are blood sugar readings stored in the resident's glucometer that are not recorded on the medication administration record (MAR) or which differ from those recorded on the MAR. Examples include:

On at a blood sugar reading of is stored in the resident's glucometer, however, this reading was not documented on the MAR

On a blood sugar reading of is stored in the resident's glucometer, however, this reading was not documented on the MAR

On , a blood sugar reading of is stored in the resident's glucometer, however, a reading of was documented on the MAR

Resident 8 gets blood sugar checks once daily. There are two readings documented on the resident's MAR that are not stored in the resident's glucometer including on , a reading of a reading of

Resident 9's glucometer readings include a , however, this reading was documented on the MAR as

Plan of Correction

Accept (- 10/08/2024)

Health Care Director entered late entry on MAR for resident 3's glucometer check for . Health Care Director entered correct glucometer for resident 9 on Resident 8 physician contacted, order clarified, prn blood sugar check to remain active.

Health and Wellness staff who administer medications shall be educated by Health Care Director on regulation

185a Implement Storage Procedures (continued)

2600.185a by 10/11/24.

Beginning 10/7/24, Health Care Director or designee will audit glucometer readings and MAR documentation 3 times weekly X4 weeks, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.185a.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented (- 10/21/2024)

187a - Medication Record

6. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.

Description of Violation

Resident 3 is prescribed to be given three times a day before meals according to a sliding scale requiring when blood sugar measures between and units of insulin when blood sugar measures . The home did not document the amount of insulin administered to Resident 3 on the following days and times:

Plan of Correction ***Accept (- 10/08/2024)***

At time of survey 9/19/24, physician contacted by Health Care Director to clarify sliding scale order, order discontinued for sliding scale due to non use.

On 9/20/24, the Healthcare Director performed an audit of remaining resident orders revealed no other residents with sliding scale insulin orders.

On 10/8/24, Health Care Director reviewed sliding scale order entry with pharmacy via phone call to avoid issues in future; pharmacist aware of need for 2 step documentations to include blood sugar and amount of insulin administered.

Staff who administer medication shall be educated on regulation 2600.187a by Health Care Director by 10/11/24.

Beginning 10/7/24, the Health Care Director or Assistant Health Care Director to review all new orders received. Beginning 10/7/24 all sliding scale insulin orders will be audited for compliance weekly X 4 weeks. This will include MAR Audit for correct insulin administration.

187a - Medication Record (continued)

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.187a.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented (- 10/21/2024)

187b - Date/Time of Medication Admin.

7. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 2 is prescribed , take one tablet twice a day for 10 days. This medication was marked as given beginning on through which means that after , there should have been 1 tablet remaining of this 10-day prescription. On , however, there were 3 tablets in the blister card meaning 2 doses were not given as prescribed, however, the MAR was marked to indicate that 19 doses had been given.

Plan of Correction ***Accept (- 10/08/2024)***

Physician notified of 2 remaining tablets on by the Healthcare Director; no new orders received. Remaining 2 tablets discarded on 9/19/24 by Healthcare Director and Assistant Healthcare Director.

Staff who administer medications shall be educated on regulation 2600.187b by Health Care Director by 10/11/24.

Beginning 10/7/24, Health Care Director or designee to audit MARs and amount of medication available on 5 random residents weekly X4 weeks to ensure compliance with regulation 2600.187b, will continue as needed.

Beginning 10/7/24, Health Care Director or designee will observe 3 med techs/nurses weekly X 4weeks to ensure compliance with regulation 2600.187b, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.187b.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented - 10/21/2024)

187d - Follow Prescriber's Orders

8. Requirements

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident 2 is prescribed Doxycycline Mono 100 MG tablets, take one tablet twice a day for 10 days. This medication was marked as given beginning on 9/10/24 at 8:00 AM and 8:00 PM through 9/19 at 8:00 AM which means that after 9:00 AM on 9/19, there should have been 1 tablet remaining of this 10-day prescription. On 9/19, however, there were 3 tablets in the blister card meaning 2 doses were not given as prescribed.

Resident 13 is prescribed a probiotic tablet, however, it was not given on 9/19 at 8:00 AM because it wasn't available in the home.

Repeated Violation - 4/2/24, 2/6/24, 12/12/23, et al., 10/4/23, et al.

Plan of Correction ***Accept (CR - 10/08/2024)***

On [redacted]4, Physician notified of 2 remaining [redacted] tablets by the Healthcare Director; no new orders received. Remaining 2 tablets discarded by the Healthcare Director and Assistant Healthcare Director on 9/19/24.

Healthcare Director and/or the Assistant Healthcare Director will perform and initial med cart audit to ensure that all medications are available as prescribed by 10/11/2024.

Staff who administer medications shall be educated on regulation 2600.187d by Health Care Director by 10/11/24.

Beginning 10/7/24 Health Care Director or designee to audit MARs and amount of medication remaining on 5 random residents weekly X 4 weeks, will continue as needed.

Beginning 10/7/24, Health Care Director or designee will observe 3 med techs/nurses weekly X 4 weeks to ensure compliance with regulation 2600.187d, will continue as needed.

Beginning at the next QMPI meeting on 10/17/24 the committee shall review audits for continued compliance with regulation 2600.187d.

Licensee's Proposed Overall Completion Date: *10/17/2024*

Not Implemented ([redacted] 10/21/2024)