

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

August 15, 2024

[REDACTED], OWNER
REGAL MANOR LLC
120 WEST MAIN STREET
WAYNESBORO, PA, 17268

RE: THE LELAND OF LAUREL RUN
120 WEST MAIN STREET
WAYNESBORO, PA, 17268
LICENSE/COC#: 32994

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/17/2024, 07/18/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE LELAND OF LAUREL RUN* License #: 32994 License Expiration: 11/26/2024
 Address: 120 WEST MAIN STREET, WAYNESBORO, PA 17268
 County: FRANKLIN Region: CENTRAL

Administrator

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

Legal Entity

Name: REGAL MANOR LLC
 Address: 120 WEST MAIN STREET, WAYNESBORO, PA, 17268
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: I-2 Date: 09/25/2012 Issued By: Boro of Waynesboro

Staffing Hours

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

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal, Complaint, Incident Exit Conference Date: 07/18/2024

Inspection Dates and Department Representative

07/17/2024 - On-Site: [REDACTED]
 07/18/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 80 Residents Served: 76
 Secured Dementia Care Unit
 In Home: Yes Area: Fourth Floor Capacity: 22 Residents Served: 21
 Hospice
 Current Residents: 7
 Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 76
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 21 Have Physical Disability: 1

Inspections / Reviews

07/17/2024 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/09/2024

08/09/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 08/15/2024
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 08/15/2024

Inspections / Reviews *(continued)*

08/12/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/15/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 08/29/2024

08/15/2024 - Document Submission

Submitted By: [REDACTED] r

Date Submitted: 08/15/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

82c - Locking Poisonous Materials

1. 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

A box of generic brand denture cleaner with a manufacturer's label indicating "call poison control center if ingested" was unlocked, unattended, and accessible to residents in resident room #406. Not all the residents of the home, including all of the residents in the Secure Dementia Care Unit (SDCU) located on the fourth (4th) floor, have been assessed capable of recognizing and using poisons safely.

Repeated Violation - 6/13/23, et al

Plan of Correction

Accept (█) - 08/12/2024)

The generic brand of denture cleaner was immediately removed from room 406 by the Director of Wellness on July 17th, 2024, and placed in a locked area to ensure it was not accessible to other residents in the secured Memory care unit. All resident's rooms in the secured dementia unit were immediately checked for items labeled "call poison control center if ingested," by the Director of Wellness on July 17th, 2024, and no other poisonous materials were found. All items labeled as poisonous materials are placed in individually labeled containers in a locked area. The facility through nursing and administration oversight, will ensure that each resident receives adequate supervision to ensure the safety of all residents in the secured Memory care unit. The LPN/ Med Techs of the secured Memory care unit will be responsible to conduct rounds twice a day to ensure that all harmful items are not in resident's rooms, the common area or spa room. The start date for the on-going compliance audit was on August 4th, 2024. Ongoing compliance will be determined by audits which will be done by the LPN/ Med Tech twice a day on the day and evening shifts for 3 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through October 6th, 2024. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, which included education on the importance of keeping poisonous materials in a locked area and was done by the Administrator. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 10/06/2024

Implemented (█) - 08/15/2024)

103f - Refrigerator/Freezer Temps

2. 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 7/18/24 at 10:15 AM, the temperature in the refrigerator in the SDCU kitchenette measured 48 degrees Fahrenheit. At 2:10 PM, the temperature was 50 degrees Fahrenheit.

Plan of Correction

Accept (█) - 08/12/2024)

The refrigerator temps were monitored by the staff on the Memory care unit immediately after the temps were found to be out of compliance. Staff were immediately instructed by the Director of Wellness not to let the door open for long periods of time when retrieving items from the refrigerator. The start date for refrigerator temps to be monitored twice a day the LPN or Med Tech was on August 5th, 2024. The start date for the audits being done twice daily for two weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks was on August 5th, 2024.

103f - Refrigerator/Freezer Temps (continued)

Refrigerator temps will be monitored twice a day by the LPN or Med Tech on day and evening shifts. Ongoing compliance will be determined by audits which will be done twice daily for 2 weeks, then 2 times a week for 2 weeks, then weekly x 4 weeks through September 30th, 2024. The reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator, which included education on the importance of immediately letting the Maintenance Director know if the freezer/refrigerator are out of compliance. One on one education was provided to the Maintenance Director to review acceptable temperatures for the refrigerator/freezer on July 31st, by the Administrator. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented (█) - 08/15/2024)

183b - Meds and Syringes Locked**3. 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 7/17/24 at 12:30 PM, there is an unlocked, unattended, and accessible tube of Phytoplex Z-Guard Paste in an unlocked drawer in the 2nd floor bathroom vanity.

On 7/18/24 at 10:00 AM, the following medications were found on the floor of resident bedroom #409:

- Round orange pill marked HH 222
- Oval yellow pill marked H125
- Two round unlabeled pink pills

Plan of Correction

Accept (█) - 08/12/2024)

The tube of Phyto plex Z-Guard Paste was immediately removed from the unlocked drawer in the 2nd floor bathroom vanity by the Director of Wellness on July 17th, 2024. Other areas of the spa room were immediately checked by the Director of Wellness on July 17th, 2024, to ensure all residents were safe from unlocked prescription medications, OTC medications and CAM. Nursing staff will be monitored for compliance of these medications by the LPNs/Med Techs who will be responsible to check the bathroom vanity on 2nd floor. The start date that the nursing staff began monitoring for compliance by checking the bathroom vanity on 2nd floor was on August 4th, 2024. This will be done daily for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator to include education on the importance of locking all prescription medications, OTC medications and CAM. On-going education will be conducted by the Administrator/Designee as determined necessary.

Medications found on the floor in room 409 were immediately removed by the Manger of the Memory care unit on July 18th, 2024. All resident rooms were checked for medications on the floor by the Director of Wellness on July 18th, 2024, to ensure the safety of all residents. No other medications were found. Five resident rooms will be checked by the LPN/Med Tech daily for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024, to ensure the safety of all residents and to determine ongoing compliance. The start date for ongoing audits was August 4th, 2024. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator and education provided on checking floors for medications

183b - Meds and Syringes Locked (continued)

dropped. Housekeeping staff was also in-serviced on the importance of removing and reporting any medications found on the floor. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 09/29/2024

Implemented (█) - 08/15/2024)

183e - Storing Medications**4. 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 7/18/24, a Victroza insulin Pen prescribed to resident #3 was found in the medication cart with a date opened of 1/12/24. According to the manufacturer's instructions, the pen states to discard 30 days after opening.

On 7/18/24 at 11:40 AM, the following medications were found loose on the floor of the 2nd floor medication room:

- An oval white pill with a "Z" embossed on each side;
- A round pink pill labeled 262
- a large round white pill marked "44" and "104"
- a round pink pill marked "lupin" and "10"

Plan of Correction

Accept (█) - 08/12/2024)

The Victroza insulin pen prescribed to resident #3, was immediately removed from the medication cart by the Manager of the Memory care unit, on July 18th, 2024. The expired insulin pen was immediately destroyed. A new pen was retrieved from resident #3's back up supplies. No medication doses were omitted. All medication carts were immediately checked by the Manager of the Memory care unit and the Director of Wellness on July 18th, 2024, and no other expired insulin pens were found. The start date for the audits for all insulin pens to be checked daily was on August 4th, 2024. All insulin pens will be checked daily by the LPN/Med Tech to ensure there are no expired insulin pens in the medication carts. Nursing staff will be assessed for ongoing compliance, by completing audits which will be done daily for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator and included education on checking all insulin pens for the expiration dates. On-going education will be conducted by the Administrator/Designee as determined necessary.

Medications found on the 2nd floor medication room floor were immediately removed by the Med Tech assigned to 2nd floor. All medication rooms were checked for medications on the floor, by the Med Techs, and no other medications were found. The start date that all med rooms were checked was on July 18th, 2024. The start date for all medication rooms checked daily was August 4th, 2024. Medication rooms will be checked daily by the Administrator/Designee, or LPNs/Med Techs for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024, to ensure ongoing compliance. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator and education provided to ensure medications have not been dropped on the floor. On-going education will be conducted by the Administrator/Designee as determined necessary.

183e - Storing Medications (continued)

Licensee's Proposed Overall Completion Date: 09/29/2024

Implemented () - 08/15/2024

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 #1 is prescribed Albuterol Sulfate inhaler as needed. On 7/18/24, this medication was not available in the home.

Resident #5 is prescribed Atropine Sulfate Ophthalmic Solution and Acetaminophen Rectal Suppository as needed. On 7/18/24, these medications were not available in the home.

Resident #2 is prescribed a blood sugar reading three (3) times per day. The 7/7/24 reading at 8:00 PM is noted on the Medication Administration Report (MAR) as 360. However, the resident's glucometer shows a reading of 340.

Resident #6 is prescribed a blood sugar reading one (1) time per day. The 7/18/24 reading at 6:00 AM is noted on the Medication Administration Report (MAR) as 132. However, the resident's glucometer does not show a reading for this date and time.

Repeated Violation - 6/13/23, et al

Plan of Correction

Accept () - 08/12/2024

The facility cannot retroactively correct the prn medications that were not available for resident #1 and resident #5. The Director of Wellness audited all resident's prn medications in Personal Care on July 23rd, 2024, and the Memory care unit on August 8th, 2024, to ensure the residents had the prn medications that have been ordered by the Physician. Resident #1's Albuterol Sulfate inhaler and resident #5's Atropine Sulfate Ophthalmic Solution and Acetaminophen Rectal Suppository were ordered and available on July 18th, 2024. The start date for the on-going audits of PRN medications was August 7th, 2024. LPN/Med Techs will be responsible for auditing the medication carts to ensure all prn medications are available. To determine ongoing compliance, audits will be done daily for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024. Reports will be reviewed by the Administrator. In-servicing of staff was implemented on July 31st, 2024, by the Administrator, and education was provided on ensuring that prn medications are available. On-going education will be conducted by the Administrator/Designee as determined necessary.

The facility recognizes that all residents could be affected by incorrect documentation of glucose readings. The Director of Wellness audited all Personal care resident's glucose readings on August 6th, 2024, and the Memory Care unit Manager audited all glucose readings for the 2 residents receiving insulin in Memory care on July 31st, 2024. Audits were completed to ensure all glucose readings/documentation were accurate. No harm was identified, however, one on one education was provided to the two Med Techs that documented the glucose readings incorrectly for resident #2 and resident #6, by the Director of Wellness on July 29th, 2024. After completing other audits,

185a - Implement Storage Procedures (continued)

several other staff were identified that documented incorrectly, and they were also in-serviced by the Director of Wellness on 8/6/2024 to ensure documentation is exactly what the glucometer reads. Staff members could not correct documentation for resident #6 and resident # [REDACTED], due to the glucometer not showing a reading. In-service of other staff was implemented on July 31st, 2024, by the Administrator, to include education that glucose readings must be documented accurately. The start date for the on-going audits of glucometer readings/documentation was July 29th, 2024. Glucometer readings/documentation will be audited daily for 3 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through October 2nd, 2024, to determine ongoing compliance. Due to other errors being identified during the facility's ongoing audits, the daily audits that will be completed daily after 3 weeks, will then be re-evaluated by the Administrator to determine if ongoing audits/education are required to be continued daily. Reports will be reviewed by the Administrator. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 10/02/2024

Implemented ([REDACTED]) - 08/15/2024)

225a - Assessment 15 Days

6. 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 receives a mechanically altered diet. Resident #4's current assessment, dated [REDACTED], does not indicate a need for an altered diet.

Plan of Correction

Accept ([REDACTED]) - 08/12/2024)

The documentation for the regular diet was corrected to read mechanically altered diet for Resident #4 by the Director of Wellness on July 18th, 2024. All assessments and new orders will be reviewed in the daily standup meeting to ensure all updates are made to the resident's assessment and reflect the resident's individualized plan of care. In-service of staff was implemented on July 31st, 2024, by the Administrator to include the importance of updating all new orders on the resident's individual assessment. The start date for the new orders and assessment to be reviewed at the daily standup meeting was August 5th, 20204. The start date for the ongoing audits by the Director of Wellness/Designee was August 5th, 2024. To determine the accuracy of the assessment documentation, The Director of Wellness/ Designee will audit 5 resident assessments daily for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 30th, 2024, to ensure the accuracy of the assessment. The facility will continue to provide care and services to attain or maintain the highest practicable physical, mental and psychosocial well- being in accordance with the assessment. Reports will be reviewed by the Administrator. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented ([REDACTED]) - 08/15/2024)

254a - Records Discharge/Active

7. Requirements

2600.

254a - Records Discharge/Active (continued)

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 7/18/24 at 10:24am, the electronic medication administration record system on the third-floor medication cart was unlocked and unattended and permitted access to personal protected information of residents including their names, medications, and medical diagnosis.

Plan of Correction**Accept ([REDACTED] - 08/12/2024)**

The facility cannot retroactively correct the electronic medication record that was left unlocked and unattended on the 3rd floor. The Med Tech immediately locked the screen of the electronic medication documentation record on July 18th at 10:24 am. The Administrator/ Designee will be responsible for doing daily walking rounds to ensure all electronic medication records have their screens hidden and locked when the medication cart is unattended. The start date of the daily walk throughs to ensure the electronic medication records have screens hidden and locked was on August 4th, 2024. In-service was implemented on July 31st, 2024, to include the importance of hiding and locking the medication report record when not attended. Education was also provided on how to lock the medication screen after the screen has been hidden. The policy regarding maintaining resident records in a confidential record was revised on July 23rd, 2024, by the Administrator, to include locking the screen of the medication record when it is unattended. The start date for the on-going compliance audits was on August 8th, 2024. To determine ongoing compliance, audits will be done daily by the Administrator/Designee for 2 weeks, then 2 times a week for 2 weeks, then weekly for 4 weeks through September 29th, 2024. Reports will be reviewed by the Administrator. On-going education will be conducted by the Administrator/Designee as determined necessary.

Licensee's Proposed Overall Completion Date: 09/29/2024**Implemented ([REDACTED] - 08/15/2024)**