

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

November 14, 2024

[REDACTED], CHIEF OPERATIONS OFFICER
LANDIS HOMES RETIREMENT COMMUNITY
1001 EAST OREGON ROAD
LITITZ, PA, 17543

RE: LANDIS HOMES RETIREMENT
COMMUNITY
1001 EAST OREGON ROAD
LITITZ, PA, 17543
LICENSE/COC#: 32177

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/30/2024, 10/01/2024, 10/02/2024 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: LANDIS HOMES RETIREMENT COMMUNITY **License #:** 32177 **License Expiration:** 06/03/2025
Address: 1001 EAST OREGON ROAD, LITITZ, PA 17543
County: LANCASTER **Region:** CENTRAL

Administrator

Name: [REDACTED]

Legal Entity

Name: LANDIS HOMES RETIREMENT COMMUNITY
Address: 1001 EAST OREGON ROAD, LITITZ, PA, 17543
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: I-1 **Date:** 12/26/2006 **Issued By:** manheim township

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 100 **Waking Staff:** 75

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Incident **Exit Conference Date:** 10/02/2024

Inspection Dates and Department Representative

09/30/2024 - On-Site: [REDACTED]
 10/01/2024 - On-Site: [REDACTED]
 10/02/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 124 **Residents Served:** 84

Secured Dementia Care Unit

In Home: Yes **Area:** lititz **Capacity:** 16 **Residents Served:** 16

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 84
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 16 **Have Physical Disability:** 1

Inspections / Reviews

09/30/2024 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/18/2024

Inspections / Reviews (*continued*)

10/17/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/13/2024
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 10/23/2024

10/17/2024 POC Submission

Submitted By: [REDACTED] Date Submitted: 11/13/2024
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 11/19/2024

11/14/2024 Document Submission

Submitted By: [REDACTED] Date Submitted: 11/13/2024
Reviewer: [REDACTED] Follow Up Type: Not Required

15a - Resident Abuse Report

2. Requirements

2600.

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 approximately [REDACTED] Staff Member A responded to a call for help from Resident #5; they were yelling, "someone help me, tell them to come quick!" Upon arrival to Resident #5's bedroom, Staff Member A witnessed Resident #4 throwing Resident #5's personal belongings around the room and the residents crying. Resident #5 reported to Staff Member A, that Resident #4 got physical with him/her, hit him/her on the left hip, and was screaming at him/her. However, this allegation of abuse was not reported to AAA via the Act 13 incident reporting form.

On [REDACTED], at [REDACTED], Staff Member B reports, Resident #1 was witnessed touching 3 other female residents' breasts during the day, resulting in staff redirecting the resident from the act, separating seating locations, and additional charting measures. The home did not report this incident to AAA until [REDACTED].

Plan of Correction

Accept [REDACTED] - 10/16/2024)

1. On 10/11/2024, Director of Personal Care submitted the correct form for the 2/10/2024 incident to AAA.
2. On 10/7/2024, Campus Supervisors (a group who assisted with the reportable incidents during non-business hours) was educated on our new process. The new process is that only personal care administrative on call team will complete reportable incidents to DHS and AAA.
3. Beginning 10/21/2024, the Interdisciplinary personal care team will be reviewing the daily 24 hour report on Point Click Care to ensure all incidents are captured.
4. On 9/13/2024, training on abuse reporting was completed with Lititz House team members. Remaining Personal Care team members will be re-educated by 11/15/2024.
5. Director of Personal Care will be responsible for auditing the revised process as (as stated above) reviewed above after any incident. Results will be reviewed and shared at our QI meetings.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented [REDACTED] - 11/14/2024)

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).

Description of Violation

On [REDACTED], at [REDACTED], Staff Member B reports, Resident #1 was witnessed touching 3 other female residents' breasts during the day, resulting in staff redirecting the resident from the act, separating seating locations, and additional charting measures. The home did not report this incident to the Department until [REDACTED].

16c - Written Incident Report (continued)

Plan of Correction

Accept [redacted] - 10/16/2024)

1. On 10/7/2024, Campus Supervisors (group who assisted with the reportable incidents during non-business hours) was educated on our new process. The new process is that only personal care administrative on call team will complete reportable incidents to DHS.
2. Beginning 10/21/2024, the Interdisciplinary personal care team will be reviewing the daily 24 hour report on PCC to ensure all incidents are captured.
3. On 9/13/2024, training on abuse reporting was completed with Lititz House team members. Remaining Personal Care team members will be re-educated by 11/15/2024.
4. Director of Personal Care will be responsible for auditing the revised process (as stated above) after any incident. Results will be reviewed and shared at our QI meetings.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented [redacted] - 11/14/2024)

17 - Record Confidentiality

4. 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 [redacted], at approximately [redacted] the residents' narcotic records were unlocked, unattended, and accessible on the medication cart in Aspen. Additionally, resident records were unattended and accessible on the computer on the medication cart, via clicking on the computer screen without a passcode.

On [redacted], at approximately [redacted] the residents' narcotic records were unlocked, unattended, and accessible on the medication cart in Birch. Additionally, resident records were unattended and accessible on the computer on the medication cart, via clicking on the computer screen without a passcode.

On [redacted], at approximately [redacted], resident specific dietary needs and medical information was unlocked, unattended, and accessible on the food line/counter in the Cedar dining room.

On [redacted] at approximately [redacted] resident specific dietary needs and medical information was unlocked, unattended, and accessible in the Lititz kitchen drawer.

Plan of Correction

Accept [redacted] - 10/17/2024)

1. On 9/30/2024, Med Tech immediately locked the Narcotics Binders in the Narcotics Box in Med Cart. Med Tech also locked the screen prohibiting anyone to see any personal resident information.
2. On 9/30/2024, Diet Rosters were removed from Dining Rooms and placed in the kitchen away from residents and visitors.
3. On 9/30/2024, Med Techs and LPNs were educated by Clinical Care Coordinator on properly locking the screens

17 - Record Confidentiality (continued)

and storing Narcotic Binders verbally and via email. Dining staff were educated by Dining Manager on proper storage and use of diet rosters verbally. All nursing and dining staff will be re-educated by 11/15/2024 by dining management and Clinical Care Coordinator.

4. A drawer in each dining room will be equipped with locking system to store diet rosters when not in use by 11/15/2024.

5. Beginning 10/21/2024, the Dining Director and Clinical Care Coordinator will audit weekly for the first month and then quarterly moving forward. Results will be reviewed and shared at our QI meetings.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented () - 11/14/2024)

42b - Abuse**6. 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

The home failed to protect Resident #3's safety in the home by neglecting to implement environmental changes ordered by physician's and therapists and supervising and monitoring the resident as ordered since their date of admission, as evidenced by the following:

- Resident #3, admitted to the home on [REDACTED], was assessed by the home on [REDACTED] to be unsafe around poisonous materials and unable to self-administer any medications. On [REDACTED], Staff Member B found Resident #3 in their bathroom in possession of medicated [REDACTED] and medicated [REDACTED], attempting to use them as toothpaste.
- Immediately upon admission, Resident #3 was crying, changing moods from angry to crying, and making the following statements: "I may as well start cutting myself," and "They better not have a knife here." The home indicated they were monitoring the resident and had the resident's son remove items from Resident #3's possession the son thought could cause harm. On [REDACTED], Resident #3 stated, "If you keep me here, I'm dead." The resident refused assistance from staff, and it is unknown how long the resident was in their room without staff monitoring. Later, when staff arrived to administer medications, Resident #3 was found with several cuts to their hands and wrists, blood on them, and blood in their bathroom; this resulted in the resident being transferred to the emergency room for a psychiatric evaluation. On [REDACTED], Resident #3's physician also reports on [REDACTED] the resident had taken small scissors and a razor and tried to cut their arms and neck.
- Resident #3's [REDACTED] emergency room discharge instructions read, we do recommend that all sharp objects be removed. On [REDACTED], Resident #3 stated to staff, he/she "was here like a caged animal and might as well kill himself/herself," then immediately pulled a paring knife from their dresser. After the incident, staff found two more additional knives in the resident's room that were never removed as ordered.
- The home initiated 1:1, staff to resident supervision ratio, for Resident #3 on [REDACTED] due to [REDACTED] and a [REDACTED]. On [REDACTED], Resident #3 was upset, agitated, and made a phone call to their family reporting their agitation. Resident #3's 1:1 staff, then left Resident #3's room, leaving the resident unsupervised during increased agitative state. By the time staff returned to the resident's room, the resident was attempting to block staff access to the room, requiring security to be called to access the room. An undetermined amount of time passed before staff could access the resident. Upon reentry of the resident's room, staff found Resident #3

42b Abuse (continued)

with a cord wrapped tightly around their neck, their face was purple but did not lose consciousness, and stated to staff, "if you wont leave, you can stand here and watch."

- Resident #3's current, [REDACTED] assessment and support plan states, objects are removed from residents' room that are potential for self harm, call bell removed from room due to it having a long cord, and on 2/2/24 occupational therapy ordered the home to remove sharp objects, no wire hangers for clothing, no plastic bags in room, and loose cables to be removed, and use wire covers as needed for items to decrease risk of injury. On [REDACTED], Resident #3 stated they wanted to slit their wrist so they could bleed to death, and on [REDACTED] the resident's physician witnessed scratches on the resident's wrists by objects such as a pen with ink marks. Again, the resident's physician ordered the home to remove all sharp objects from the resident's room. On [REDACTED] Resident #3 voiced wanting to use glass to cut their wrists. On [REDACTED], Resident #3 was upset and stated, "I'd rather die than stay here" and when the home checked on the resident, they were agitated and drawing on their wrists and arms with markers. The home reports the resident is no longer being provided 1:1, staff to resident supervision, allowing the resident an undetermined amount of time independently spent in their bedroom daily. During the onsite inspection of Resident #3's bedroom on [REDACTED], the following items were found accessible to the resident in their bedroom:
 - the call bell with a cord approximately 3 feet in length next to their toilet
 - approximately 5 wire hangers in their closet
 - multiple plastic bags in their window bench seat drawer
 - a telephone and clock cord that could be pulled away from the wall exposing more than 1 foot of cord
 - a long cord from their lamp that was not secured to the wall using a wire cover
 - a large glass flower vase on their windowsill
 - a glass bottle of perfume in their bathroom
 - a glass bottle sitting on their sink in their bathroom
 - a pen on their window seat in their room

Plan of Correction**Accept [REDACTED] - 10/17/2024)**

Resident #3 resides on the Lititz House, Secure Dementia Care Unit, creams found on 1/17/24 were immediately removed from the resident's bathroom.

1. At the time of inspection, all items mentioned in this Licensing Inspection Summary were removed immediately. The residents' family was notified items were being removed and felt the removal of the items would cause more problems than it would have done good, since resident #3 behaviors had improved.
2. Resident #3 made no additional suicidal attempts since 1/20/24. Resident #3's Provider was changed to Landis Homes Medical Director on 1/30/2024, with regular Provider follow up visits.
3. Resident #3 family was/is active and engaged with resident's plan of care.
4. Chaplain support provided to Resident #3
5. Resident #3 Assessment and Support Plan updated on [REDACTED] to include items that are permitted per Provider order. The items permitted in Resident #3's room include plants in pots, one trash bag in trash can, pictures on the wall with glass, and electrical cords secured with cord covers. These items were placed back in the resident room. The call bell cord in bathroom was shortened. Per provider order on 10/9/24, resident currently does not require 1:1 supervision. Resident has not had any ideations since August 31, 2024. Resident was seen by psychiatry services on 2/22/24, at this time, family declined continued psychiatry services. Resident was later seen on 9/4/24 by psychiatry and psychology services on 9/11/24. During visits by psychiatry/psychology services, resident denied depression

42b - Abuse (continued)

and anxiety. Resident currently on psychiatry services for 1-3 month duration.

6. Director of Personal Care and VP of Health Services reviewed and updated current policy and procedure on Resident Harm to Self or Others on 10/17/24. Staff will be educated on updated policy and procedure by 11/15/2024 by Director of Personal Care and Clinical Care Coordinator. Copy of Policy and Procedure placed in all care bases including Lititz House on 10/17/24. Resident RASP updated on 10/17/2024 by Director of Personal Care to include direction to staff if procedure needs to be enacted.

7. Education provided to family and team members of which items are permitted/not permitted in the resident's room by 11/15/24.

8. Beginning the week of 10/21/24, auditing of the permitted/nonpermitted items in the room will be completed weekly by the Team Leader in the Lititz Secure Dementia Care Unit.

9. Auditing results will be reviewed and shared in the QI Meetings by the Director of Personal Care.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented (█ - 11/14/2024)

141a 1-10 Medical Evaluation Information**8. Requirements**

2600.

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

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #2's initial, █ medical evaluation did not include their dietary needs. The field to indicate this is left blank and additional documents are not included with the medical evaluation to include the resident's dietary needs. Per the home, and resident's 2/22/24 assessment and support plan, the resident is to follow a regular diet with chopped meats and thin liquids.

Resident #9's initial, █ medical evaluation did not include their dietary needs. The field to indicate this is left blank and additional documents are not included with the medical evaluation to include the resident's dietary needs.

Plan of Correction

Accept (█ - 10/17/2024)

1. On 10/3/2024, Director of Personal Care re-educated Clinical Care Coordinator and Admission Nurse on the DME regulations to ensure regulatory compliance.
2. New DMEs that address dietary needs will be completed by PCP by 11/15/2024.

141a 1-10 Medical Evaluation Information (continued)

- 2. All resident charts will be audited by 11/15/2024 to ensure compliance by the Personal Care Interdisciplinary Team.
- 3. Beginning 10/21/2024, Clinical Care Coordinator will audit all new DMEs prior to admission or annual updates.
- 4. Results will be reviewed and shared at our QI meetings by Director of Personal Care.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented () - 11/14/2024

171b4 - Staff Training

9. Requirements

2600.

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

Description of Violation

On () at () Staff Member E independently transported Resident #8 to another location on campus. However, Staff Member E has not completed and passed the Department-approved direct care training course and passing of the competency test.

Plan of Correction

Directed () - 10/17/2024

- 1. As of 10/1/2024, no volunteer shuttle driver will be without a certified DCW until all certificates are completed.
- 2. All shuttle drivers are volunteers. Shuttle driver volunteers will be enrolled in the DHS Direct Care Worker course on 11/4/2024 and 11/11/2024. Certificates will be complete by 11/15/2024.
- 3. Director of Volunteers will be responsible for ensuring all new volunteers complete the DCW certificate upon orientation.
- 4. Beginning November 2024, Monthly auditing will be completed by the Director of Volunteers. Results will be reviewed and shared at our QI meetings by the Director of Personal Care.

(Directed)

In addition to the above plan of correction: Beginning November 1, 2024, monthly auditing will be completed by the Director of Volunteers. Results will be reviewed and shared at our QI meetings by the Director of Personal Care.

Directed Completion Date: 11/15/2024

Implemented () - 11/14/2024

225a - Assessment 15 Days

10. 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.

225a Assessment 15 Days (continued)

Description of Violation

Resident #1's annual [REDACTED] assessment and support plan, reads they are independent and require no plan of support with irritability, judgement, agitation, aggression, hallucinations and communication needs. However, Resident #1 has a history of inappropriately touching other residents which has led the home to initiate frequent checks, alert charting, and room modifications to attempt to redirect the inappropriate touching. Furthermore, on [REDACTED] the home reports Resident #1 requires hearing aids due to their hearing loss and on [REDACTED], Resident #1 kept reporting, "I can't hear", had extreme difficulty with communication, and wasn't wearing their hearing aids.

Resident #1's bed was affixed with a bedside mobility device. Resident #1's annual [REDACTED] assessment and support plan, does not include the resident's ability to use the device safely for the purpose it was intended or identification of the specific device to be used.

Resident #1's [REDACTED], medical evaluation reads, the resident it to follow a mechanical soft diet with thin liquids. However, the resident's [REDACTED] assessment and support plan reads, the resident is to follow a mechanical soft diet and may have regular texture dessert.

Plan of Correction**Directed ([REDACTED] - 10/17/2024)**

Resident resides in SDCU.

1. Residents' RASP was updated by Personal Care Social Worker on [REDACTED] to reflect support needed due to irritability, judgement agitation, hallucinations and communication needs and intervention related to inappropriate touching.
2. Resident has history of losing [REDACTED] hearing aids. On [REDACTED] residents' RASP was updated to include direction on how we store hearing aids in the SDCU care base. Education for team members on removal and addition of hearing aids completed by [REDACTED] by Clinical Care Coordinator.
3. On [REDACTED], residents' RASP was updated by Director of Personal Care updated to include the brand of bed enabler used. [REDACTED] RASP does include residents' ability to use bed enabler safely as indicated by PT evaluation.
4. Therapy screen requested on [REDACTED] to make recommendation on residents' diet. RASP will be updated after therapy clarification no later than [REDACTED].
5. Clinical Care Coordinator will educate Admission Nurse and Household Leads on proper RASP creation and use to reflect regulatory compliance by 11/15/24.
6. New procedure for RASP creation and updating will be finalized and implemented by [REDACTED] by Director of Personal Care and Clinical Care Coordinator.
7. Results will be reviewed and shared at our QI meetings by Director of Personal Care.

(Directed)

In addition to the above plan of correction, beginning no later than 11/1/2024, monthly audits will be completed by the administrator or designee on 10% of resident's assessment and support plans to ensure they are current and appropriately reflect the resident's needs. Documentation of completed audits, updated assessment and support plans as well as staff education will be kept by the home and available for review by the Department.

Directed Completion Date: 11/15/2024

Implemented ([REDACTED] - 11/14/2024)

231b - Medical Evaluation

11. Requirements

2600.

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

Description of Violation

Resident #3 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]; however, the resident’s medical evaluation was completed on [REDACTED]

Plan of Correction

Accept ([REDACTED] - 10/17/2024)

1. On 10/2/2024, Director of Personal Care re-educated Clinical Care Coordinator and Admission Nurse on the DME regulations to ensure regulatory compliance.
2. All resident charts will be audited by 11/15/2024 to ensure compliance by the Personal Care Interdisciplinary Team.
3. Beginning 10/21/24, Clinical Care Coordinator or designee will audit all new DMEs prior to admission or annual updates.
4. Results will be reviewed and shared at our QI meetings by Dir of Personal Care.

Licensee's Proposed Overall Completion Date: 11/15/2024

Implemented ([REDACTED] - 11/14/2024)