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

November 18, 2024

[redacted], ADMINISTRATOR
LEEDS HEALTH CARE SERVICES INC
[redacted]

RE: HEATHER COURT
281 IRONSTONE DRIVE
NORTHUMBERLAND, PA, 17857
LICENSE/COC#: 22706

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/23/2024 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *HEATHER COURT* **License #**: *22706* **License Expiration**: *12/29/2024*

Address: *281 IRONSTONE DRIVE, NORTHUMBERLAND, PA 17857*

County: *NORTHUMBERLAND* **Region**: *NORTHEAST*

Administrator

Name:

Legal Entity

Name: *LEEDS HEALTH CARE SERVICES INC*

Address:

Certificate(s) of Occupancy

Type: *I 2* **Date**: *09/21/2017* **Issued By**: *NECU*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *96* **Waking Staff**: *72*

Inspection Information

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

Reason: *Renewal, Incident* **Exit Conference Date**: *10/23/2024*

Inspection Dates and Department Representative

10/23/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *48* **Residents Served**: *48*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *48* **Have Physical Disability**: *0*

Inspections / Reviews

10/23/2024 - Full

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *11/16/2024*

Inspections / Reviews *(continued)*

11/18/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *11/18/2024*
Reviewer: [redacted]
Follow Up Type: *Bypass Document Submission*

11/18/2024 Bypass Document Submission

Submitted By: [redacted]
Date Submitted: *11/18/2024*
Reviewer: [redacted]
Follow Up Type: *Not Required*

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 [redacted], at approximately [redacted], Department representative observed narcotic logbooks in the side slots of the medication carts, unlocked and unattended.

Plan of Correction ***Accept ([redacted] - 11/18/2024)***

Narcotic logbooks have been secured/locked within respective medication carts as depicted in attached photo. During staff meetings held on 11/14/24, Charge staff were updated on requirement to keep narcotic logbooks locked. (See attached meeting sign-in sheet and agenda). Nursing Supervisor will conduct weekly audits of narcotic logbooks to ensure logbooks are secured in areas that are confidential. See attached audit. Audits will continue until 100% accuracy is met for 6 consecutive weeks. Administrator to spot check audits every other week. See attached Administrator Spot Check tool.

Licensee's Proposed Overall Completion Date: *11/14/2024*

Implemented ([redacted] - 11/18/2024)

42b - Abuse

2. 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 [redacted] at approximately [redacted] resident #1 was observed in their bedroom standing over their roommate's bed, resident #2, performing a sexual act. Both residents have a diagnosis of [redacted]. The incident was observed by staff person D.

Repeat Violation: 5/7/24, 8/15/24

Plan of Correction ***Accept ([redacted] - 11/18/2024)***

Resident #1 was immediately redirected following the incident.
Area Agency on Aging notified of incident on [redacted] and report filed. See attached.
DHS notified of incident. See attached reportable incident.

Resident #1 was relocated to a new unit and a new room on the morning of [redacted] as a result of the noted incident.

Abuse retraining of all staff was conducted at staff meetings held on [redacted]. See attached meeting agenda and sign-in sheet.

Licensee's Proposed Overall Completion Date: *11/14/2024*

42b Abuse *(continued)*

Implemented (- 11/18/2024)

42c Treatment of Residents

3. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

On 4 at approximately , residents # 3, # 4, and # 5 were seated in a common area of the home together. Resident # 3 was observed shoving their walker into resident # 4's legs multiple times and then a moment later resident # 3 pushed their walker into resident # 5. Resident # 3 also then hit resident # 5 on the right side of the head with their hand. Resident # 5 responded by striking resident # 3 with their shoe on the side of resident # 3's leg.

Plan of Correction ***Accept - 11/18/2024)***

All residents were immediately redirected to different areas of the unit following the incident.

Area Agency on Aging notified of incident on 10/09/24 and reports filed.

DHS notified of incident. See attached reportable incident.

Abuse retraining of all staff was conducted at staff meetings held on 11/14/24. See attached meeting agenda and sign-in sheet.

Licensee's Proposed Overall Completion Date: *11/14/2024*

Implemented - 11/18/2024)

65g Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff A and Staff B did not complete annual fire safety education by a fire safety expert or person trained by a fire safety expert for the 2023 training year.

Plan of Correction ***Accept (- 11/18/2024)***

(trained by Fire Safety Expert) conducted fire safety education training during routine staff meetings held on 11/14/2024. See attached meeting agenda and sign-in sheet. Such trainings have been incorporated into annual staff training plans moving forward.

Licensee's Proposed Overall Completion Date: *11/14/2024*

Implemented - 11/18/2024)

81b - Resident Personal Equipment

5. Requirements

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

Description of Violation

The enabler bar attached to the bed in resident room C109 was not securely attached to the bed. The bar was able to be pulled back and forth and the mattress had also slid to the side creating a gap between the bar and the bed.

Repeat Violation: 12/19/23

Plan of Correction ***Accept (- 11/18/2024)***

Enabler bar in resident room C109-1 was properly secured to the bed frame on 11/12/24. See attached photo. Monthly audits of enabler bars in use will be completed by Administrator to ensure enablers are safely secured to beds. Audits will continue until 100% accuracy is met for three consecutive months. See attached administrator audit tool.

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

Implemented - 11/18/2024)

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

During the initial walk through the following items were found in the Cambridge Unit's laundry room:
- *One white spray bottle with the words "Odoban Air Freshner" handwritten in black marker on it*
- *One white spray bottle with the words "Dawn Water" handwritten in black marker on it*
- *One clear spray bottle with the words "Spray and Wash" and "Peroxide and Multi Surface" handwritten in black marker on it.*

The spray bottles were not stored affixed with original labels.

Repeat Violation: 12/19/23

Plan of Correction ***Accept (- 11/18/2024)***

Improperly labeled chemicals have been removed from laundry room as of 11/12/24 and chemicals in original containers are in place. See attached photo. Weekly audits will be conducted by the administrator to ensure that chemicals are stored in original containers with manufacturer's labels. Audits will continue until 100% efficiency is reached for six consecutive weeks. See attached administrator audit tool.

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

Implemented (- 11/18/2024)

85d - Trash Receptacles

7. Requirements

2600.

85d - Trash Receptacles *(continued)*

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The AB pantry area trash can and the trash can in the Beswick kitchen both did not have lids on them when observed during the initial walk through.

Plan of Correction ***Accept (- 11/18/2024)***

Trash can lids were available and are being utilized for trash cans effective 11/12/24. See attached photos. Staff were educated during meetings held on 11/14/24 regarding the importance of ensuring trash can lids are in place. See attached meeting sign-in sheet and agenda. Administrator will conduct weekly audits to make sure trash can lids are in place. Audits will continue until 100% efficiency is reached for six consecutive weeks. See attached administrator audit tool.

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

Implemented (- 11/18/2024)

125a - Combustible Storage

9. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

A collection of lint was found behind the dryer and along the exhaust vents behind the dryer in the Avon laundry area.

Plan of Correction ***Accept (- 11/18/2024)***

Area behind dryer was cleaned by housekeeper on duty on 10/24/24. See attached photo. A weekly audit will be completed by Director of Nursing to ensure areas behind dryers are free of lint. See attached audit tool. Audits will continue until 100% accuracy is achieved for 6 consecutive weeks. Administrator will spot check audits every other week for compliance. See attached administrator audit tool.

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

Implemented (- 11/18/2024)

185a - Implement Storage Procedures

10. 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 #6 is prescribed as needed for . Resident #8 is prescribed powder for . However, these medications were not available in the home at the time of inspection.
The Medication Administration record of Resident #9 indicated that they had a blood glucose level of on Their Glucometer did not have a corresponding reading for this date and time.

Repeat Violation: 12/19/23

Plan of Correction ***Accept (- 11/18/2024)***

Resident #6's was present on date of inspection (see attached photo with received date on bottle).

185a - Implement Storage Procedures (continued)

Resident #8's [redacted] is currently in stock at the facility. See attached photo. Recording Glucometer readings in MARs and medication administration procedures were reviewed with charge staff during staff meetings on 11/14/24. See attached meeting sign-in and agenda.

Medication audit will be conducted weekly by Nursing Supervisor until 100% accuracy is achieved for 4 consecutive weeks. See attached audit. Administrator to spot check audits every other week for completion. See administrator audit tool.

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

Implemented [redacted] - 11/18/2024)

187b - Date/Time of Medication Admin.

11. 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 # 1 has an order for [redacted] tablet, one tablet at bedtime. It was reported by the home that on [redacted] the medication was initialed as administered by staff person E on the resident Medication Administration Record (MAR) and on the narcotic count sheet but was not administered to the resident.

Plan of Correction ***Accept [redacted] - 11/18/2024)***

Medication administration procedures were reviewed with charge staff during staff meetings on 11/14/24. See attached meeting sign-in and agenda.
MAR record audit for resident #1 will be conducted weekly by Nursing Supervisor until 100% accuracy is achieved for 4 consecutive weeks. See attached audit. Administrator to spot check audits every other week for completion. See administrator audit tool.

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

Implemented ([redacted] - 11/18/2024)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

Resident # 1 has an order for [redacted], one tablet at bedtime. On [redacted] the medication was not administered to the resident as ordered by the prescriber.

Repeat Violation: 8/15/24

Plan of Correction ***Accept ([redacted] - 11/18/2024)***

Medication administration procedures were reviewed with charge staff during staff meetings on 11/14/24. See attached meeting sign-in and agenda.
MAR audit for resident #1 will be conducted weekly by Nursing Supervisor until 100% accuracy is achieved for 4

187d - Follow Prescriber's Orders (continued)

consecutive weeks. See attached audit. Administrator to spot check audits every other week for completion. See administrator audit tool.

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

Implemented ████ - 11/18/2024)

233c - Key-Locking Devices

14. Requirements

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

Description of Violation

The gates in both the Avon courtyard and the Dover House courtyard are operated with a keypad installed next to the gates. The keypads in both courtyards did not have directions for their operation or the codes to operate the keypads posted on or near the devices.

Plan of Correction ***Accept ████ - 11/18/2024)***

Instructions were replaced at the patio gate for the Avon and Dover units on 11/14/24 (see attached photos). Weekly audits will be completed by Nursing Supervisor to ensure codes are present for all key-locking devices. Audits will be completed until 100% efficiency is reached for 8 consecutive weeks. See attached Locking Instructions Audit tool. Administrator will spot check
every two weeks until goal is achieved. See attached administrator audit tool.

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

Implemented ████ - 11/18/2024)

234d - Support Plan Revision

15. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

On ████ resident # 6 had inappropriate contact with their roommate and has made numerous advances towards female residents according to staff interviews. The support plan dated ████ was not updated to reflect the incident and these consistent behaviors and does not include a plan to address the behaviors.

Plan of Correction ***Accept ████ - 11/18/2024)***

RASP for resident #1 (not #6 as indicated in LIS) has been updated. See attached RASP. RASP reviews will be completed by nursing supervisor on 5 randomly selected residents per month. Reviews will continue until there are no errors for 3 consecutive months. See attached audit tool. Administrator will complete monthly spot checks until goal is achieved. See attached administrator audit tool.

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

Implemented (████ - 11/18/2024)