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

April 7, 2025

COLUMBIA/WEGMAN SOUTHAMPTON,LLC

RE: THE PROVINCE OF SOUTHAMPTON
1160 STREET ROAD
SOUTHAMPTON, PA, 18966
LICENSE/COC#: 14538

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/09/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE PROVINCE OF SOUTHAMPTON* **License #**: *14538* **License Expiration**: *04/04/2025*

Address: *1160 STREET ROAD, SOUTHAMPTON, PA 18966*

County: *BUCKS* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/10/2019* **Issued By**: *Upper Southampton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *124* **Waking Staff**: *93*

Inspection Information

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

Reason: *Complaint, Incident, Monitoring* **Exit Conference Date**: *12/09/2024*

Inspection Dates and Department Representative

12/09/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Reflections* **Capacity**: *36* **Residents Served**: *18*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *75*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *49* **Have Physical Disability**: *0*

Inspections / Reviews

12/09/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/02/2025*

01/14/2025 - POC Submission

Submitted By: **Date Submitted**: *02/07/2025*
Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/07/2025*

Inspections / Reviews *(continued)*

04/07/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *02/07/2025*

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 , at 9:38 AM, torn off tops of three medication blister packs , containing resident medication information were observed unlocked, unattended, and accessible on top of the second-floor medication cart near room

The tops contained the following information:
-
.

Repeat violation: et al, and .

Plan of Correction ***Accept 01/14/2025)***

At the time of inspection, the former Healthcare Director immediately discarded the torn tops of the tablet for resident the tablet for resident and the tablet for resident

The Administrator/Designee will educate current Med Techs and Nurses on regulation 2600.17. This will be completed by 1/6/25. As part of this training, the Administrator/Designee will train the Med Techs and Nurses to discard resident information appropriately. The Administrator/Designee will also train the Med Tech and Nurses on HIPPA and how to identify and prevent HIPPA violations. Documentation shall be retained.

Beginning 12/27/24, the Administrator/Designee will maintain record confidentiality.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented - 02/25/2025)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident record did not contain a statement signed by the resident acknowledging receipt of a copy of the resident rights and complaint procedures.

Repeat violation. et al and .

Plan of Correction ***Accept (- 01/14/2025)***

On , the Administrator obtained Resident signed statement acknowledging a copy of the resident

41e Signed Statement (continued)

rights and complaint procedures.

The Administrator will educate the Business Office Manager and sales Directors on the requirements of 2600.41.e by 1/6/25. Documentation will be retained.

The Business Office Manager and the Administrator shall audit new and current resident records to ensure that each record contains a signed statement by the resident acknowledging receipt of a copy of the resident rights and complaint procedures. Missing acknowledgments shall be obtained, and corrections shall be completed by 1/24/25.

The Administrator will review Resident Rights at the next Resident Council meeting by 1/15/25.

Beginning 12/27/24 and ongoing, the Administrator/Designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.41e, Signed Statement. Ongoing compliance will be maintained, and documentation will be retained and made available for review by the Department.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented - 02/25/2025)

42s - Privacy

3. Requirements

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On at least 10 occasions during the summer of 2024, resident invited resident to room to watch tv. When resident was ready for bed told resident leave, however, resident refused to leave. Resident requested assistance from staff members to have resident removed on these occasions. Resident stated that staff members told that since resident was invited in, it was up to resident to convince to leave.

Plan of Correction ***Accept - 01/14/2025)***

Resident #3 and #4's assessment and support plan will be reviewed and updated, as applicable, with any social and recreational needs not identified by the Administrator/Designee by 1/6/25.

The Administrator will review Resident Rights at the next Resident Council meeting by 1/15/25.

The Administrator/Designee will educate current Direct Care Staff on regulation 2600.42s, explicitly focusing on the resident's right to privacy. The training will include documenting any concerns and notifying responsible parties/physicians. This will be completed by 1/6/25. Documentation shall be retained.

Beginning 1/6/25, the Administrator/Designee will interview Resident #3 and Resident #4 weekly for four weeks to ensure they feel their right to privacy is being upheld and do not feel neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment, or disciplined in any way.

Immediately, the home will keep documentation of any completed incident reviews, resident record updates, resident and staff education, and resident interviews, which will be made available for review by the Department. Identified occurrences shall be reported per Department reporting requirements.

42s Privacy (continued)

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented [redacted] - 02/25/2025)

65d - Initial Direct Care Training

5. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

1. Training that includes a demonstration of job duties, followed by supervised practice.
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.
3. Initial direct care staff person training to include the following:
   - i. Safe management techniques.
   - ii. ADLs and IADLs
   - iii. Personal hygiene.
   - iv. Care of residents with dementia, mental illness, cognitive impairments, an intellectual disability and other mental disabilities.
   - v. The normal aging-cognitive, psychological and functional abilities of individuals who are older.
   - vi. Implementation of the initial assessment, annual assessment and support plan.
   - vii. Nutrition, food handling and sanitation.
   - viii. Recreation, socialization, community resources, social services and activities in the community.
   - ix. Gerontology.
   - x. Staff person supervision, if applicable.
   - xi. Care and needs of residents with special emphasis on the residents being served in the home.
   - xii. Safety management and hazard prevention.
   - xiii. Universal precautions.
   - xiv. The requirements of this chapter.
   - xv. Infection control.
   - xvi. Care for individuals with mobility needs, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, if applicable to the residents served in the home.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services on [redacted]. However, staff person A did not complete and pass the Department approved direct care training course and pass the competency test until [redacted].

Plan of Correction ***Accept [redacted] - 01/14/2025)***

The Department approved direct care training course and competency test were not completed for Staff Person A under the prior management company, Leisure Care. The new management company, Legend Senior Living, discovered this deficiency in March 2023 and completed the training Staff Person A. Staff Person A has been employed without concern.

An audit of initial direct care training was conducted on 4/17/24, and no other issues were identified since Legend Senior Living corrected them in February 2023.

The Administrator/Designee will educate the Business Office Manager/Designee to conduct an audit on the first

65d Initial Direct Care Training (continued)

day of hire to ensure all required paperwork is complete in the required timeframe. This will be completed by 1/6/25. Documentation shall be retained.

Beginning 12/27/24, the Administrator will review new hire documentation and approve the completion of the new hire checklist via signature and date.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented - 02/25/2025)

65e - 12 Hours Annual Training

6. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.
1. Staff person orientation shall be included in the 12 hours of training for the first year of employment.
2. On the job training for direct care staff persons may count for 6 out of the 12 training hours required annually.

Description of Violation

Direct care staff person A annual training hours for could not be determined because home did not document length of trainings.

Plan of Correction ***Accept (- 01/14/2025)***

At the time of the inspection, the home was unable to print the Relias transcript for Staff person A to show their training hours for the period 1/1/23 12/31/23. Staff person A completed 22.81 hours of annual training in 2023.

On 12/31/24, the Regional Director of Operations educated the Administrator/Designee on obtaining Relias transcripts that indicate the length of training for all staff.

Beginning on 12/27/24 and continuing, the Business Office Manager/Designee shall review all completed annual training to ensure that staff members complete it when assigned.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented 02/25/2025)

65f - Training Topics

7. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

65f - Training Topics *(continued)*

Description of Violation

Direct care staff person A did not receive training in medication self-administration training, instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, and personal care service needs of the resident during training year [redacted].

Repeat violation: [redacted].

Plan of Correction ***Accept [redacted] - 01/14/2025)***

Under the prior management company, Leisure Care, Staff person A failed to receive medication self-administration training. Unable to correct this, the new management company, Legend Senior Living, instituted electronic training recording utilizing an online tool, Relias, in addition to in-person training. Staff Person A complies with the 2024 annual training and has a documented 2025 training plan. All training documentation shall be kept.

The Administrator/Designee will educate current Med Techs on medication self-administration. This will be completed by 1/6/25. Documentation shall be retained.

Training with an overview will be added to the community's Annual Training Schedule. The Administrator/Designee will ensure this training is completed as assigned. See Copy of Annual Training Schedule.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented [redacted] - 04/07/2025)

65g - Annual Training Content

8. 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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in resident rights during training year [redacted].

Repeat violation: [redacted]

Plan of Correction ***Accept [redacted] - 01/14/2025)***

At the time of the inspection, the home was unable to print the Relias transcript for Staff Person A to show their training hours for the period 1/1/23–12/31/23. Staff person A completed 0.51 hours of resident rights training in 2023.

On 12/31/24, the Regional Director of Operations educated the Administrator/Designee on obtaining Relias

65g - Annual Training Content (continued)

transcripts that indicate staff training. Documentation shall be retained.

Beginning on 12/31/24 and continuing, the Business Office Manager/Designee shall review completed annual training to ensure that staff members complete it when assigned.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented (- 04/07/2025)

65i - Training Record

9. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home's record of direct care staff training does not include length of each course.

Plan of Correction ***Accept (- 01/14/2025)***

At the time of the inspection, the home was unable to print the Relias 2024 Training Plan, which includes the length of each course.

On 12/31/24, the Regional Director of Operations educated the Administrator/Designee on obtaining Relias training plans that indicate the length of training for current staff.

On 12/31/24, the Administrator educated the Business Office Manager/Designee on Regulation 2600.65i, Training Record, utilizing the staff file audit tool. Documentation shall be retained.

Beginning 12/31/24 and continuing, the Business Office Manager/Designee shall review completed new hire files to ensure a training record is created for all new hires in compliance with 2600.65i, Training Record.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented (- 02/25/2025)

103d - Storing Food Off Floor

10. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On at 3:28 PM, 3 plastic bags of ice were stored on the floor of the walk-in freezer in the main kitchen area.

Plan of Correction ***Accept (01/14/2025)***

Upon discovery during the 12/9/24 inspection, the Chef immediately discarded the 3 plastic bags of ice. The bags of ice were left over from an event the evening before and should have been discarded.

On 12/10/24, the Administrator educated the Chef/Designee on Regulation 103d, focusing on safe food handling and storage.

103d Storing Food Off Floor (continued)

The Chef/Designee will educate all kitchen staff on Regulation 2600.103d, focusing on safe food handling and storage. This will be completed by 1/6/25. Documentation shall be retained.

The Chef/Designee will complete a weekly audit to ensure all food items are stored appropriately. This audit will be completed and documented weekly for four weeks beginning 1/6/25. After that, weekly observation audits will continue, and the Administrator will oversee compliance.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented (- 02/25/2025)

103i - Outdated Food

11. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On at 3:48 PM there was an unlabeled, whole fish product stored in a box of bacon wrapped scallops.

Repeat violation. and

Plan of Correction ***Accept - 01/14/2025)***

Upon discovery during the 12/9/24 inspection, the Chef immediately discarded the whole fish product and bacon wrapped scallops. These were leftovers from an event the evening before and should have been discarded.

On 12/10/24, the Administrator educated the Chef/Designee on Regulation 103i, focusing on safe food handling and storage.

The Chef/Designee will educate all kitchen staff on Regulation 2600.103i, focusing on safe food handling and storage. This will be completed by 1/6/25. Documentation shall be retained.

The Chef/Designee will complete a weekly audit to ensure all food items are stored appropriately. This audit will be completed and documented weekly for four weeks beginning 1/6/25. After that, weekly observation audits will continue, and the Administrator will oversee compliance.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented - 02/25/2025)

141a - Medical Evaluation

12. 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.

141a - Medical Evaluation *(continued)*

Description of Violation

Resident was admitted to the home on . The initial medical evaluation for resident was not completed until

Plan of Correction ***Accept S - 01/14/2025)***

The home no longer employs the Healthcare Director responsible for this deficiency. Upon their hire, the newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.141a1. This will be completed by 1/30/25.

The Administrator/Designee will audit current resident and new admission DMEs for compliance with regulation 2600.141a1. This will be completed by 12/31/24.

If Discrepancies are identified on the DME, they will be identified on the Audit tool. The Administrator Director/Designee will contact the healthcare provider and have the DME corrected and filed in the resident's medical record. The Healthcare Director/Designee will document this communication with the physician in the resident's medical record and notify the Administrator.

Beginning 12/27/24 and ongoing, the Administrator/Designee shall review new admission files within 30 days of admission to ensure compliance with Regulation 2600.141a1, Resident Medical Evaluation and Health Care. The Administrator will maintain ongoing compliance, and documentation will be retained.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented - 02/25/2025)

141b1 - Annual Medical Evaluation

13. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident most recent medical evaluation was completed on . The home provided an incomplete medical evaluation form dated that does not list the day the resident was evaluated on, resident's height or weight, and is not signed by a medical professional. Residents previous medical evaluation was completed on .

Plan of Correction ***Accept - 01/14/2025)***

The former Healthcare Director failed to complete Resident 's most recent medical evaluation thoroughly.

Unable to correct the medical evaluation for Resident . On 12/31/24, the Regional Healthcare Specialist requested a new medical evaluation from the physician. This updated medical evaluation will be retained in the resident file and made available to the Department at their request.

The newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.141b1 upon hire. This will be completed by 1/30/25. Documentation will be retained.

The Administrator/Designee will audit current resident and new admission DMEs for compliance with regulation

141b1 - Annual Medical Evaluation (continued)

2600.141b1. This will be completed by 12/31/24.

If Discrepancies are identified on the DME, they will be identified on the Audit tool. The Administrator Director/Designee will contact the healthcare provider and have the DME corrected and filed in the resident's medical record. The Healthcare Director/Designee will document this communication with the physician in the resident's medical record and notify the Administrator.

Beginning 12/27/24 and ongoing, the Administrator/Designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.141b1, Annual Medical Evaluation. The Administrator will maintain ongoing compliance, and documentation will be retained.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented (- 04/07/2025)

181f - Record of Medication

14. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On , resident record did not include a current list of medications. The list in the resident's record did not contain over the counter medications: or . The list of current medications included tablets which the resident stated no longer takes.

Plan of Correction ***Accept (- 01/14/2025)***

The Administrator removed , and from Resident apartment upon discovery during the 12/9/24 inspection.

During the 12/9/24 inspection, it was discovered that the home could not provide the Department with physician orders for Resident , or discontinued

On 12/10/24, the Regional Healthcare Specialist completed a Self-Administration Assessment on Resident and determined the resident may self-administer these medications.

On 6/16/24, was prescribed, and the prescription was discontinued. On 12/31/24, a verbal order request was sent to the physician for and . Upon discovering this order, the was returned to Resident .

Beginning 1/6/25, the Administrator/Designee will audit current resident apartments for residents that self-administer medications, ensuring that any medication has a corresponding prescription on record. This audit will be completed by 1/13/25.

The Administrator will maintain ongoing compliance, and documentation will be retained.

Licensee's Proposed Overall Completion Date: *01/14/2025*

181f Record of Medication *(continued)*

Implemented (███ 02/25/2025)

183e Storing Medications

15. 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 ███ resident ███ blister pack of ███, was punctured at pill 13, and the pill was still in the package.

Resident ███ blister pack of ███ tablet was punctured at pill 11, and the pill was still in the package.

Resident ███ blister pack of ███ was punctured at pill 4, and the pill was still in the package.

Resident ███ blister pack of ███ was punctured at pill 28, and the pill was still in the package.

Resident ███ blister pack of ███ was punctured at pill 14, and the pill was still in the package.

Repeat violation: ███ and ███.

Plan of Correction ***Accept (███ - 01/14/2025)***

Upon notification during the inspection on ███ the former Healthcare Director immediately properly discarded Resident ███ pill ███ and pill ███, Resident ███ pill ███, Resident ███ pill ███, and Resident ███ pill ███.

On 12/27/24, the Regional Healthcare Specialist and the Pharmacy Representative performed an audit on Medication Carts in the home. The audit found no additional medication packages were damaged. Medications were found to be stored per the manufacturer's recommendation and in a manner that prevented damage.

The Administrator/Designee will educate Med Tech/Nurses that when an individual medication blister package has been compromised/damaged, the medication shall be destroyed per Pennsylvania regulation. This will be completed by 1/6/25. Documentation shall be retained.

Beginning 12/27/24, the Healthcare Director/Designee will be responsible for the continued compliance of all certified Med Techs and Nurses.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented (███ - 04/07/2025)

185a Implement Storage Procedures

16. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

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 is prescribed , tablet, capsule, , and tablet, all prescribed as needed. On these medications were not available in the home.

Plan of Correction ***Accept - 01/14/2025)***

Upon notification during the inspection on 12/9/24, the Administrator immediately obtained an order to discontinue Resident tablet, tablet, capsule, tablet, and tablet, due to non-use on

On 12/27/24, the Regional Healthcare Specialist and the Pharmacy Representative audited all Medication Carts in the community. They found no additional missing medications.

The Administrator/Designee will educate Med Tech/Nurses on implementing storage procedures that include safe storage, access, security, distribution, and use of medications per Pennsylvania regulation. This will be completed by 1/6/25. Documentation shall be retained.

Beginning 12/27/24, the Healthcare Director/Designee will be responsible for the continued compliance of all certified Med Techs and Nurses.

Licensee's Proposed Overall Completion Date: *01/07/2025*

Implemented - 02/25/2025)

17. Requirements

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

Description of Violation

On , the home did not have procedures in place to correctly count and manage control substances. Staff was unable to describe how system worked, and medication counts for multiple controlled substances were not correct, with some having negative counts. Staff persons B and C were observed during a shift change narcotic count. When narcotic counts did not match medication available, staff input the new number of medications without noting or determining how the discrepancy occurred.

December 2024 medication administration record for resident shows a decrease in available by 1 pill daily from to then an increase of 1 pill daily from to

Plan of Correction ***Accept (01/14/2025)***

During the inspection on 12/9/24, the Administrator immediately notified the Regional Healthcare Director regarding the concerns with the electronic narcotic count within the eMAR system and determined that paper narcotic count sheets would be initiated.

On 12/10/24, the Administrator educated Med Tech/Nurses on the use of paper narcotic count sheets, which were instituted.

185a - Implement Storage Procedures (continued)

On 12/27/24, the Regional Health Care Director and Pharmacy representative audited all controlled substances and validated that the correct count was obtained.

The Administrator/Designee will educate Med Tech/Nurses on implementing storage procedures that include safe storage, access, security, distribution, and use of medications per Pennsylvania regulation. This will be completed by 1/6/25. Documentation shall be retained.

Beginning 1/6/25, the Administrator/Designee shall observe one shift count weekly for the next four weeks. The Administrator/Designee shall reconcile incorrect counts and provide re-education, as applicable.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all certified Med Techs and Nurses.

Licensee's Proposed Overall Completion Date: *02/04/2025*

Implemented - 02/25/2025)

190c - Record of Training

18. Requirements

2600.
190.c. A record of the training shall be kept including the staff person trained, the date, source, name of trainer and documentation that the course was successfully completed.

Description of Violation

The home's medication administration training record for staff person B does not include documentation of successful completion of the training.

Repeat violation .

Plan of Correction ***Accept - 01/14/2025)***

The former Healthcare Director and former Administrator failed to ensure Staff Person B's medication administration training record was obtained upon hire on . Upon notification during the inspection on 12/9/24, The new Administrator pulled Staff Person B from the Med Cart and placed them on the direct care staff rotation.

On 12/10/24, the Regional Healthcare Specialist enrolled Staff Person B in the department-approved Medication Administration training program. Staff person B completed the training on 12/13/24 and their initial observations on 12/13/24. Staff person B returned to their Med Tech position on 12/14/24.

All Medication Technicians shall obtain their Observation Paperwork, if applicable. If unable to do so, the Med Techs will be removed from the schedule until they are re-trained by a Pennsylvania-certified trainer by 12/31/24.

By 1/24/25, the Regional Healthcare Specialist/Designee, certified trainers, will complete all due observations, and all medication technician paperwork will be current.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all certified Med Techs and Nurses.

190c Record of Training *(continued)*

Licensee's Proposed Overall Completion Date: *01/25/2025*

Implemented - 02/25/2025)

191 - Resident Right to Refuse

19. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident admitted , has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat violation: et al and

Plan of Correction ***Accept - 01/14/2025)***

On the Administrator obtained Resident s signed statement acknowledging the right to question or refuse medication if the resident believes there may be a medication error.

The Administrator will educate the Business Office Manager and sales Directors on the requirements of 2600.191 by 1/6/25. Documentation will be retained.

The Business Office Manager and the Administrator shall audit new and current resident records to ensure that each record contains a signed statement by the resident acknowledging receipt of a copy of the resident rights and complaint procedures. Missing acknowledgments shall be obtained, and corrections shall be completed by 1/24/25.

The Administrator will review Resident Rights at the next Resident Council meeting by 1/15/25.

Beginning 12/27/24 and ongoing, the Administrator/Designee shall review all new admission files within 30 days of admission to ensure compliance with Regulation 2600.191, Resident Education. Ongoing compliance will be maintained, and documentation will be retained and made available for review by the Department.

Licensee's Proposed Overall Completion Date: *01/16/2025*

Implemented 02/25/2025)

224a - Preadmission Screen Form

20. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident was admitted to the home on ; however, the resident's preadmission screening form was completed on

Plan of Correction ***Accept (- 01/14/2025)***

The former Healthcare Director and Administrator failed to complete the resident preadmission screening form

224a Preadmission Screen Form (continued)

before the [redacted] admission.

The Regional Healthcare Specialist conducted an internal audit on 10/11/24, discovered the missing document, and completed the form on 10/14/24.

The home no longer employs the Healthcare Director responsible for this deficiency. Upon their hire, the newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.224a. This will be completed by 1/30/25. Documentation shall be retained.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all Preadmission Screening Forms.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented [redacted] - 02/25/2025)

225a - Assessment 15 Days

21. 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 [redacted] was admitted on [redacted]; however, the resident's assessment was not completed until [redacted]

Plan of Correction ***Accept ([redacted] - 01/14/2025)***

The former Healthcare Director and Administrator failed to complete the resident assessment form within 15 days of admission on 8/31/24.

The Regional Healthcare Specialist conducted an internal audit on 10/11/24, discovered the missing document, and completed the form on this date.

The home no longer employs the Healthcare Director responsible for this deficiency. Upon hire, the newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.225a. This will be completed by 1/30/25. Documentation shall be retained.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all Assessment forms.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented [redacted] - 02/25/2025)

225c - Additional Assessment

22. Requirements

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

225c - Additional Assessment *(continued)*

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

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

Plan of Correction ***Accept - 01/14/2025)***

The former Healthcare Director and Administrator failed to complete the resident annual assessment form before 5/24/24.

The Regional Healthcare Specialist conducted an internal audit on 10/11/24, discovered the missing document, and completed the form on 10/22/24.

The home no longer employs the Healthcare Director responsible for this deficiency. Upon their hire, the newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.225c. This will be completed by 1/30/25. Documentation shall be retained.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all Assessment forms.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented - 02/26/2025)

227d - Support Plan Medical/Dental

23. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident dated , indicates the resident has a need for some assistance with turning and positioning, however the description of service need and plan to meet service need is not completed. Additionally resident has a bed rail on the side of bed which is not listed in support plan.

When bedside mobility devices are being used, the Resident Support Plan must reflect:
The specific need for the device,
The intended Use,
Any risks associated with the device,
The resident's ability to use the device safely for the intended purpose,
Identification of the specific device to be used,
If a cover is required to meet FDA guidelines.

Repeat violation: et al and

227d Support Plan Medical/Dental (continued)

Plan of Correction ***Accept [redacted] - 01/14/2025)***

During the inspection on [redacted], the Administrator was notified of Resident [redacted] bed enabler and removed it from the bed, as Resident [redacted] verbalized their non use of the equipment.

The Administrator/Designee will educate Direct Care Staff on Resident Support Plan Needs and the use of bed enablers per Pennsylvania regulation. This will be completed by 1/6/25.

The home no longer employs the Healthcare Director responsible for this deficiency. Upon their hire, the newly hired Healthcare Director will be trained by the Administrator/Designee on Regulation 2600.227d. This will be completed by 1/30/25. Documentation shall be retained.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all Assessment forms.

Licensee's Proposed Overall Completion Date: *02/01/2025*

Implemented [redacted] - 02/25/2025)

233c - Key-Locking Devices

24. Requirements

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

Description of Violation

On [redacted], the directions for operating the home's locking mechanism are not conspicuously posted near the doors to the Secure Dementia Care Unit (SDCU), because the code posted for the locking mechanism was incorrect.

Plan of Correction ***Accept ([redacted] 01/14/2025)***

The Maintenance Director corrected the key code posting on 12/9/24 and ensured and tested that the keypad and Key Code were programmed correctly.

On 12/9/24, the Administrator educated the Maintenance Director/Designee on Regulation 2600.233c, Key Locking Devices. The documentation will be retained.

The Maintenance Director/Designee will complete a weekly audit of the directions for operating the key locking devices posted in a conspicuous location near the device. This audit will be completed and documented weekly for four weeks beginning on 1/6/25.

Then, beginning 2/1/25, the Maintenance Director/Designee will monitor them through monthly inspections. Documentation will be maintained in TELS, the community online building management tracker.

Beginning 12/27/24, the Administrator/Designee will be responsible for the continued compliance of all key locking device directions.

Licensee's Proposed Overall Completion Date: *02/04/2025*

Implemented [redacted] - 02/25/2025)

254a - Records Discharge/Active

25. Requirements

2600.
254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On [redacted] at 9:40 AM, records for current and discharged residents, including home health care records, were unlocked, unattended, and accessible in the computer room.

Plan of Correction ***Accept [redacted] - 01/14/2025)***

During the inspection on 12/9/24, the Maintenance Director was notified of this deficiency and placed a new locking device for the computer room door that automatically locks upon closure. The door requires a key to open but automatically locks when the self-closing door is closed.

The Maintenance Director/Designee will complete a weekly audit of the computer room door to ensure the records are secure. This audit will be completed and documented weekly for four weeks beginning on 1/6/25.

Beginning 2/1/25, the Maintenance Director/Designee will monitor the locking mechanism of this door through monthly inspections. Documentation will be maintained in TELS, the community online building management tracker.

Beginning 12/27/24, the Maintenance Director/Designee will be responsible for the continued compliance of all key-locking doors.

Licensee's Proposed Overall Completion Date: *02/04/2025*

Implemented ([redacted] 02/25/2025)