pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

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

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

Located at **31 MILLERSVILLE ROAD, LANCASTER, PA 17603**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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

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

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

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

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

and shall remain in effect from **June 11, 2025** until **December 11, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **333061**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 11, 2025

[redacted], Regional Operations Director
Lancaster PCH LLC
31 Millersville Road
Lancaster, PA 17603

RE: Legend Personal Care and Memory Care of Lancaster
31 Millersville Road
Lancaster, PA 17603
License/COC #: 333060

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on February 25, 2025, February 26, 2025, February 28, 2025, April 16, 2025, April 17, 2025, and May 8, 2025 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance #333060 dated July 9, 2024 until July 9, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (4); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 11, 2025 to December 11, 2025.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date:

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per Resident X Per day	Calculated Fine = Per Day	Mandated Correction Date (to avoid Fine)

Pennsylvania
Department of Human Services

42(b)	II	77	$5	$385	5 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected and full compliance with the regulation has been achieved by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

, Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Forum Place, 6th Floor
PO Box 2675
Harrisburg, PA 17105-2675

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Pennsylvania
Department of Human Services

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

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

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *07/09/2025*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

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

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

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

Certificate(s) of Occupancy

Type	Date	Issued By
I-1	*12/11/2004*	*Manor Township*
I-2	*12/11/2004*	*Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *128* **Waking Staff**: *96*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/28/2025*

Inspection Dates and Department Representative

02/25/2025 - On-Site: [redacted]

02/26/2025 - On-Site: [redacted]

02/28/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *90*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *40* **Residents Served**: *36*

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *90*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *38* **Have Physical Disability**: *0*

Inspections / Reviews

02/25/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/31/2025*

04/08/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/11/2025*

04/11/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/01/2025*

06/03/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 2/25/25, the home's most recent renewal license inspection summary (LIS), dated 4/9/25, partial inspection LIS, dated 5/30/24, and partial inspection LIS, dated 10/3/24, were not posted in a conspicuous and public place in the home.

Plan of Correction ***Accept (- 04/08/2025)***

-On 2/28/2025, the LIS for 4/9/25, 5/30/25 and 10/3/25 were posted by the Residence Director.
-By 3/15/2025, regional director of operations shall educate the administrator and front office staff on regulation 2600.3c. Documentation shall be kept.
-Beginning 3/15/2025, the administrator shall round weekly X 4 weeks to observe for posted current license.
-To ensure consistent adherence to Regulation 2600.3c, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Proposed Overall Completion Date: 05/01/2025

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

5a1 - DHS Access

2. Requirements

2600.

5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:

1. Agents of the Department.

Description of Violation

On 2/25/25, at 9:45 AM, the census of current residents with the demographic information needed to choose a sample was requested. This information was again requested at 10:30 AM. However, this information was not received until 11:45 AM.

On 2/25/25, at 11:30 AM, the administrator's record was requested. However, the administrator's complete record of training was not provided until 2/26/25 at 9:45 AM.

On 2/25/25, at 9:45 AM, the fire drill records from 2024 to current were requested. However, the entirety of these records was not provided until 2/26/25 at 9:30 AM.

On 2/26/25, at 11:05 AM, the medication training records for Staff Persons B and C were requested. However, these records were not provided until 2/26/25 at 1:45 PM.

On 2/25/25, at 9:45 AM, the reportable incidents for 2024 and 2025 were requested. The 2025 incidents were

5a1 - DHS Access (continued)

provided at 10:20 AM. At 11:35 AM, the 2024 reportable incidents were requested again. The 2023 reportable incidents were received. These 2023 reportable incident were taken back to exchange for 2024 reportable incidents at 11:49 AM. At 1:05 PM, the 2024 reportable incidents were requested again. At approximately 2:00 PM, the agent of the Department was informed that the 2024 incidents could not be found, and that Staff Person A would attempt to print them from the emails which had been sent to the main office for the legal entity of the home.

Plan of Correction ***Accept (█ - 04/08/2025)***

-By 3/15/2025, the Regional Director of Operations shall educate the administrator and management team on regulation 2600.5a1 to ensure multiple department managers are aware of the requirement and location of requested items. Documentation shall be kept.
-By 3/15/2025, the administrator organized a state ready binder to include items frequently requested by the department. The administrator and department head team are aware of the location of this binder.
-Beginning 3/15/2025, the administrator shall audit the binder monthly X 6 months for survey readiness.
-To ensure consistent adherence to Regulation 2600.5a1, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025. documentation shall be kept, further ensuring our commitment to transparency and accountability.

Proposed Overall Completion Date: 05/01/2025

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

5a2 - Aging Access

3. Requirements

2600.
5.a. The administrator or a designee shall provide, upon request, immediate access to the home, the residents and records to:
2. Representatives of the area agency on aging.

Description of Violation

On 2/7/25, at 12:00 PM, a representative of Protective Services with the Lancaster County Area Agency on Aging requested access to Resident #7's records, including the face sheet, medication list, care plan, nursing notes, incident reports, and staff names and phone numbers. The representative didn't receive these documents until 2/11/25 at 3:04 PM.

Plan of Correction ***Accept (█ - 04/11/2025)***

-By 3/15/2025, the Regional Healthcare Director shall educate the administrator and assistant healthcare director on regulation 2600.5a2 and the process for accessing for resident records including electronic record access. Documentation shall be kept.

By 4/10/2025, the administrator shall educate the department managers on regulation 2600.5a2 and the process for accessing resident records including electronic record access. Documentation shall be kept.

5a2 - Aging Access (continued)

-By 3/15/25, the assistant healthcare director reviewed resident clinical charts/records to ensure frequently requested items by the local area agency on aging are included and current. The administrator and assistant Healthcare director, as well as the department managers are aware of the location of the information in the charts/records and are able to assist the local area agency on aging as requested.

-Beginning 3/15/2025, the administrator shall audit the resident charts/records monthly X 6 months for accuracy.

-To ensure consistent adherence to Regulation 2600.5a2, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

15a - Resident Abuse Report

4. 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 1/20/25, at approximately 9:45 AM, Resident #1 placed hands up Resident #2's shirt and down Resident #2's pants. This incident was not reported to the local police department or the local area agency on aging.

On 2/10/25, at 9:45 AM, Resident #1 placed hands in Resident #2's pants and was moving back and forth. This incident was not reported to the local police department or the local area agency on aging.

Plan of Correction ***Accept (- 04/11/2025)***

-On 1/27/2024 the health care director submitted reports to Aging for incident that occurred on 1/20/2025.

-On 2/10/2024 the administrator submitted reports to Aging for incident that occurred on 2/10/2025.

-On 2/27/2025, the administrator contacted Manheim township police to make them aware of incidents occurring on 1/20/2025 and 2/10/2025.

-By 3/15/2025, the Regional Director of Operations or the Regional Healthcare Director shall educate department managers on regulation 2600.15a to include notifying the police and local area agency of aging. Documentation shall be kept.

15a - Resident Abuse Report (continued)

-Beginning 3/15/2025, the administrator shall audit reportable incidents and abuse reports for proper reporting weekly x 6 weeks.

-To ensure consistent adherence to Regulation 2600.15a, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

16c - Written Incident Report

5. 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 sometime after 6:00 PM, Emergency Medical Services (EMS) were called to take Resident #7 to the hospital for an acute illness. A Report of Need was completed by the County Adult Protective Services for investigation into alleged neglect of Resident #7. This incident of emergency transfer to the hospital with the allegation of neglect was not reported to the Department.

Repeated Violation - 5/30/24, et al and 4/9/24, et al

Plan of Correction ***Accept (- 04/11/2025)***

-On 4/10/2025 the Administrator reported the incident from involving resident 7 to DHS.

-By 3/15/2025, the Regional Director of Operations shall educate the administrator and management team on regulation 2600.16c to ensure department managers are aware of the requirement for reporting incidents.

-By 3/15/2025, the administrator organized a state ready binder to include items frequently requested by the department. The administrator and department head team are aware of the location of this binder.

-Beginning 3/15/2025, the assistant healthcare director, or designee shall review clinical incident reports daily for reportable incidents X 6 weeks.

-To ensure consistent adherence to Regulation 2600.16c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 06/03/2025)

17 - Record Confidentiality

6. 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 2/28/25, from 12:19 PM until 12:23 PM, the computer atop medication cart 1 in the Secured Dementia Care Unit (SDCU) was unlocked, unattended, and accessible. Resident #4's name and prescribed medications were on the screen.

Plan of Correction ***Accept (- 04/08/2025)***

-At time of survey on 2/28/25, the computer screen was secured by the med tech.
-By 3/25/2025, the administrator shall educate current staff on regulation 2600.17. Documentation shall be kept.
-Beginning 3/15/2025, the administrator or designee shall audit common areas including med carts for record confidentiality weekly X 6 weeks.
-To ensure consistent adherence to Regulation 2600.17, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Proposed Overall Completion Date: 05/01/2025

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented (- 06/03/2025)

42b - Abuse

7. 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 1/20/25, at approximately 9:45 AM, Resident #1 placed hands up Resident #2's shirt and down Resident #2's pants. Staff Member E witnessed this incident.

On , sometime after 6:00 PM, Resident #7 was visited by Power of Attorney (POA). The POA for Resident #7 had been contacted by Resident #7's who alerted the POA that Resident #7 was ill at approximately 4:00 PM. Upon arrival, sometime after 6:00 PM, the POA found Resident #7 in a recliner, covered in emesis. Emesis was found on the floor, and in two trash cans beside the recliner. Furthermore, Resident #7 told POA that had been in the recliner since the previous night. Resident #7 was found to be soaked through clothing, the incontinence pad and into recliner with urine and feces. The POA went to seek assistance from staff at the

42b - Abuse (continued)

home and requested that Resident #7's vitals be taken and primary care physician (PCP) contacted. Staff Member O took the resident's temperature, which was 101.1 degrees. Staff Member O informed the POA that [redacted] had administered Tylenol one hour prior and the resident's fever was lower than it had been. This was confirmed by Resident #7's Medication Administration Record (MAR). In a witness statement, Staff Member O stated [redacted] had gone to report the resident's condition to the home's Health Care Director. The POA requested to have Emergency Medical Services (EMS) contacted. Resident #7 was transferred to the emergency room and diagnosed [redacted]. As of 2/26/25, Resident #7 was [redacted] and would not be moving back to the home. During the interview with the POAs for Resident #7, they indicated that they had not been notified of any change in status of the resident.

On 2/10/25, at 9:45 AM, Resident #1 placed [redacted] hands down Resident #2's pants and was moving [redacted] hands back and forth.

On 2/25/25, at 9:45 AM, Resident #3 grabbed Resident #5's arm and hand. As a result of the incident, Resident #5 sustained a bruise to [redacted] right hand. While on-site, Resident #5 reported to an agent of the Department that [redacted] hand still hurts. Resident #5 also stated that [redacted] was afraid at the time of the incident and remains afraid of running into Resident #3 who hurt [redacted]

On 2/26/25, at 8:20 AM, in the SDCU dining room, Resident #2 was standing by Resident #1. Resident #1 was rubbing Resident #2's stomach and attempting to put [redacted] hand down Resident #2's pants.

Repeated Violation - 10/3/24, et al

Plan of Correction ***Accept ([redacted] - 04/08/2025)***

-On 1/20/2025 residents were immediately separated, reports made to DHS/ AAA and support plans updated for each resident.
- On [redacted] following residents' incident multiple staff attempted to assist resident with cleaning up emesis.
-On 2/10/2025 residents were immediately separated, reports made to DHS/ AAA and support plans updated for each resident.
-On 2/25/25 residents were immediately separated, reports made to DHS/ AAA and support plans updated.
-2/26/25 residents were immediately separated, reports made to DHS/ AAA/ Manheim township police, one on one care giver hours extended for resident 1 to 24hrs per day and support plans updated for each resident.
-On [redacted] resident 1 was given a 30-day notice to vacate.
-By 3/25/2025, the administrator shall educate current staff on abuse, de-escalation techniques and redirection and interventions. Documentation shall be kept.
-By 4/30/2025, the Ombudsman or Area Office of Aging to hold an in-service for current staff on abuse and abuse reporting. Documentation shall be kept.
-Beginning 3/15/2025, the administrator or designee shall interview 5 SDU resident's weekly X 6 weeks to inquire about safety.
-At the next resident council meeting on 4/23/2025, the administrator shall discuss abuse with residents. Documentation shall be kept.
-To ensure consistent adherence to Regulation 2600.42b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

42b - Abuse *(continued)*

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented (█ - 06/03/2025)

65f - Training Topics

8. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct care Staff Person C did not receive training in the following areas during the 2024 training year:

- *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.*

Direct care Staff Person D did not receive training in the following areas during the 2024 training year:

- *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.*
- *Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.*

Plan of Correction ***Accept (█ - 04/08/2025)***

-By 3/15/2025, the administrator shall educate staff person C on the following topics, documentation shall be kept:
-medication self-administration
-meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

-By 3/15/2025, the administrator shall educate staff person D on the following topics, documentation shall be kept:
-medication self-administration
-meeting the needs of the residents as described in the preadmission screening form, Assessment tool, medical evaluation, and support plan
-care for residents with mental illness and an intellectual disability

-By 3/15/2025 the administrator shall review the 2025 training plan for thoroughness and the inclusion of required topics.
-By 3/24/2025 administrator will educate department managers on regulation 2600.65f documentation shall be kept.
-By 3/15/2025, current associate training records for 2024 shall be reviewed by administrator for completion of required trainings. Associates in need of training shall be trained by 5/1/2025 by the administrator or designee.

-Beginning 3/15/2025, the administrator or designee shall review Relias training completion monthly to ensure trainings are completed as assigned. Associates in need of training completion shall be addressed and scheduled time to complete.

65f - Training Topics (continued)

-To ensure consistent adherence to Regulation 2600.65g compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented (█ - 06/03/2025)

65g - Annual Training Content

9. 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:

Description of Violation

Direct care Staff Person D did not receive training in the following areas during the 2024 training year:

- *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.*

Plan of Correction ***Accept (█ - 04/11/2025)***

-On 1/30/25, staff person D received Fire Safety training by Maintenance Director as part of an "all staff" training. Documentation shall be kept.

-On 3/15/2025 Administrator provided customer service associate with training surrounding regulation 2600.65g.

-By 3/15/2025, current associate training records for 2024 shall be reviewed by administrator for completion of required trainings. Associates in need of training shall be trained by 5/1/2025 by the administrator or designee.

-Beginning 3/15/2025, the administrator or designee shall review Relias training completion monthly to ensure trainings are completed as assigned. Associates in need of training completion shall be addressed and scheduled time to complete.

-To ensure consistent adherence to Regulation 2600.65g compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

91 - Telephone Numbers

10. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers posted including the nearest hospital and fire department on or by the telephone in the Secure Dementia Care Unit (SDCU) "Reminiscence Lounge".

Plan of Correction ***Accept (- 04/08/2025)***

-On 2/28/2025, at time of survey, the required telephone numbers were placed by the phone in the SDU Reminiscence Lounge by administration.
-By 3/15/2025, the administrator or designee shall audit all phones for proper posting of emergency telephone numbers. Phones found not in compliance shall be corrected at time of audit.
-By 3/22/2025, the administrator shall educate current staff on regulation 2600.91. Documentation shall be kept.
-Beginning 3/15/2025, the administrator or designee shall audit phones weekly X 6 weeks.
-To ensure consistent adherence to Regulation 2600.91 compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

105g - Lint Removal and Duct Cleaning

11. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 2/25/25, there was an approximate 1/4-inch accumulation of lint in the lint trap of the dryer in the Main Laundry room and in the resident laundry of the Personal Care Home as well as in the dryer of the main laundry room in the Secure Dementia Care Unit (SDCU). There were no clothes in the dryers at the time.

Plan of Correction ***Accept (- 04/11/2025)***

-On 2/25/25 at time of survey, the lint was removed from the dryer lint traps by the administrator.

-On 2/25/25 at time of survey, remaining dryers were checked for lint by the administrator, no further finding noted.

-By 3/15/2025, the administrator shall educate current staff on regulation 2600.105g and the importance of removing lint from dryer lint traps. Documentation shall be kept.

105g - Lint Removal and Duct Cleaning (continued)

-Beginning 3/1/2025 maintenance director shall audit dryer lint traps 3X weekly X 6 weeks to ensure adherence to regulation.

-By 3/1/2025, the maintenance director shall post signage on the dryers as a reminder to residents and associates to remove lint from dryer lint traps.

-To ensure consistent adherence to Regulation 2600.105g compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Not Implemented (- 06/03/2025)

124 - Notice to Fire Department

12. Requirements

2600.
124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home does not have documentation of written notification to the local fire department of the address of the home, location of the bedrooms, and the assistance needed to evacuate in an emergency.

Plan of Correction ***Accept (- 04/08/2025)***

-On 4/3/2025, notice to the Fire Department was sent by administrator via USPS. Documentation has been kept.
-By 3/15/2025, the Regional Director of Operations shall educate the administrator and maintenance director on regulation 2600.124. Documentation shall be kept.
-Beginning 4/3/2025, the administrator shall create a repeating monthly calendar notification as a reminder to send monthly updates to the Fire Department. The notifications to the Fire Department shall be sent monthly to the Fire Department via email, documentation shall be kept.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

126a - Furnace Inspection

13. Requirements

2600.
126.a. A professional furnace cleaning company or trained maintenance staff person shall inspect furnaces at least annually. Documentation of the inspection shall be kept.

Description of Violation

The home has multiple natural gas furnaces and are not able to provide documentation that these furnaces have been inspected within the last year.

Plan of Correction ***Accept (- 04/08/2025)***

-On 4/15/2025, the furnaces are scheduled to be inspected by Inc. Documentation shall be kept.

126a - Furnace Inspection (continued)

-By 4/15/2025, the administrator shall educate the Maintenance Director on regulation 2600.126a, documentation shall be kept.
-By 4/15/25, the maintenance director and administrator shall create a calander reminder for annual furnace inspection and cleaning to be scheduled.
-To ensure consistent adherence to Regulation 2600.126.a, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

126b - Furnace Cleaning

14. Requirements

2600.
126.b. Furnaces shall be cleaned according to the manufacturer's instructions. Documentation of the cleaning shall be kept.

Description of Violation

The home has multiple natural gas furnaces and are unable to provide documentation that these furnaces have been cleaned within the last year.

Plan of Correction ***Accept (█ - 04/08/2025)***

-On 4/15/2025, the furnaces are scheduled to be cleaned by █ Inc. Documentation will be kept.
-By 3/15/2025, the administrator shall educate the Maintenance Director on regulation 2600.126b, documentation shall be kept.
--By 4/15/25, the maintenance director and administrator shall create a calander reminder for annual furnace inspection and cleaning to be scheduled.
-Beginning 4/17/2025, the Maintenance Director shall schedule annual furnace inspections and cleanings. A task has been created in TELS as a reminder.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

132d - Evacuation

15. Requirements

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

Description of Violation

The fire drill on 2/22/24, at 1:15 PM, took 20 minutes to evacuate. The home's maximum evacuation time is 15 minutes.

132d - Evacuation *(continued)*

Plan of Correction ***Accept (█ - 04/08/2025)***

-On 3/15 maintenance director was re-educated on 2600.132.d by administrator.
-By 4/10/2025, the Maintenance Director shall educate current staff on regulation 2600.132d, the community's specified evacuation time and their responsibilities during fire evacuations. Documentation shall be kept.
-Beginning 3/15/2025, the administrator shall audit fire drills monthly. Should Fire drills be outside the designated evacuation time; the fire drill shall be repeated and additional associate training shall be provided by the Maintenance Director.
-To ensure consistent adherence to Regulation 2600.132d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

144c1 - Smoking Area Guidelines

16. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

On 2/25/25, at 10:30 AM, Staff Member G was seen inhaling from a vaping device while in route to dispose of trash in the outside dumpster. At that time, there were multiple cigarette butts, at least 15, scattered about the enclosed area outside of the kitchen and where the dumpsters are kept. In addition, there is an area where cigarette butts were scraped against the cement to extinguish them. These areas are not a designated smoking area.

On 2/26/25, at 1:31 PM, Resident #6 was observed sitting on a chair in the courtyard smoking a pipe. The courtyard is not a designated smoking area.

Plan of Correction ***Accept (█ - 04/11/2025)***

-On 2/26/2025, the administrator cleaned the area outside of the kitchen and around the dumpster area, cigarette butts were removed.

- On 2/26/2025, the administrator observed the remaining outdoor areas of the community for cleanliness and cigarette butts, no additional findings noted.

-On 2/26/2025 Staff member G received counseling and education on regulation 2600.1441 by the administrator.

-The administrator had a conversation with resident 6 and resident 6's POA on 3/17/2025 in regards to smoking

144c1 - Smoking Area Guidelines (continued)

and designated areas.

-By 3/25/2025, the administrator shall educate current associates on the community's smoking policy, designated smoking area and regulation 2600.144c1. Documentation shall be kept.

-At the next resident council meeting scheduled for 4/23/2025 , the administrator will educate residents on the community's smoking policy and the designated smoking area. Documentation shall be kept.

-Beginning 3/15/2025, the administrator or designee shall round 3 X weekly in designated and non-designated smoking areas to ensure associates and residents are compliant with smoking areas.

-To ensure consistent adherence to Regulation 2600.144c1, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 06/03/2025)

171b5 - First Aid Kit

17. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:
5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the wheelchair van used to transport residents does not include antiseptic.

Plan of Correction ***Accept (█ - 04/08/2025)***

-On 2/28/2025, antiseptic was replaced in the first aid kit in the wheelchair van by administrator and a zip tie type closure was placed on the first aid kit to indicate it is appropriately stocked and ready for use.
-By 3/15/2025, the administrator or designee shall audit remaining first aid kits for proper contents. A zip tie type closure shall be placed on each kit indicating it is properly stocked and ready for use.
-By 3/25/2025, the administrator shall educate current associates on regulation 2600.171b5, associates shall also be educated on the need to inform the Healthcare Director or designee each time the first aid kit is used to ensure supplied are restocked. Documentation shall be kept.
-Beginning 3/15/2025, the administrator or designee shall audit the first kits monthly X 3 months.
--To ensure consistent adherence to Regulation 2600.171b5, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

183d - Prescription Current

18. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 2/28/25, Fluticas 1000/Salmeterol 50 INHL Disk 60 prescribed for Resident #9, was in the home's overflow medication; however, the home does not have a current order for this medication.

On 2/28/25, Mupirocin 2% ointment prescribed for Resident #11, was found in the medication cart; however, this medication was discontinued on 2/24/25.

Plan of Correction ***Accept (█ - 04/08/2025)***

-On 2/28/25, at time of survey, resident 9's Fluticas 1000/Salmeterol 50 INHL Disk 60 was removed and discarded by assistant healthcare director.
-On 2/28/25, at time of survey, resident 11's Mupirocin 2% ointment was removed and discarded by assistant healthcare director.
-By 4/11/2025, medication carts shall be audited by assistant healthcare director or designee to ensure discontinued medications have been removed.
-By 3/25/2025, the Healthcare Director or designee shall educate associates who administer medications on regulation 2600.183d. Documentation shall be kept.
-Beginning 4/15/2025, the Healthcare Director or designee shall review orders for discontinuation orders 3 X week.
--To ensure consistent adherence to Regulation 2600.183d, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

184a - Resident's Meds Labeled

19. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #9 is prescribed Furosemide 40 mg tablet with orders to take one tablet by mouth every morning for edema. However, the pharmacy label on this medication states to take one tablet by mouth daily due to hypertension. Handwritten on the top of this label states "8:00 AM, Take 2 tablets".

Plan of Correction ***Accept (█ - 04/08/2025)***

-On 2/28/25, at time of survey, a "see MAR" sticker was placed on resident 9's Furosemide by assistant healthcare director. Pharmacy was contacted, refill requested with proper label per physician order.
-By 4/11/2025, assistant health care director audited medication carts for properly labeled medications.
-By 3/25/2025, the Healthcare Director or designee shall educate associates who administer medications on regulation 2600.184a, documentation shall be kept.
-Beginning 4/15/2025, assistant health care director shall audit medication carts weekly X 6 weeks.
--To ensure consistent adherence to Regulation 2600.184a, compliance monitoring will be conducted during the

184a - Resident's Meds Labeled (continued)

QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

185a - Implement Storage Procedures

20. 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 2/17/25, at 8:00 AM, Resident #10's Medication Administration Record (MAR) had a documented a blood glucose reading of 134. However, this reading was not in the resident's glucometer.

On 2/24/25, 12:00 PM, Resident #10's MAR had a documented a blood glucose reading of 148. However, this reading was not in the resident's glucometer.

Plan of Correction ***Accept (█ - 04/08/2025)***

-By 3/25/2025, the Healthcare Director or designee shall educate associates who administer medications on regulation 2600.185a. Documentation shall be kept.
-By 4/11/2025, the Healthcare Director or designee shall audit remaining glucometers and MARs.
-Beginning 4/1/2025, the associates who administer medications will audit glucometers each shift during shift count. Documentation shall be reviewed by Healthcare Director or designee.
-Beginning 4/15/2025, Healthcare Director or designee shall audit glucometers and MARs weekly X 6 weeks.
-To ensure consistent adherence to Regulation 2600.185a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (█ - 05/30/2025)

187d - Follow Prescriber's Orders

21. Requirements

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

Description of Violation

Resident #1 is prescribed Esomepraxol Mag Dr 40 mg cap with orders to take 1 capsule by mouth daily for gastroesophageal reflux disease. However, on 2/4/25, at 6:00 AM, this medication was not administered.

187d - Follow Prescriber's Orders (continued)

Resident #1 is prescribed Metoprolol Tartrate 25 MG tab with orders to take 1 tablet by mouth 2 times a day for hypertension and to "hold if SBP less than 100 or HR less than 60". However, on 2/26/25, at 8:00 AM, this medication was not administered, and vital signs were not taken.

Resident #9 is prescribed Midorine HCL 5mg tablet with orders take 1 tablet by mouth 3 times daily for hypotension and to "hold for BP over 140/90". However, on 2/13/25, at 9:00 PM, this medication was not administered, and vital signs were not taken.

Resident #9 is prescribed Nystatin 100,000 UN/GM with orders to apply topically to groin twice daily until resolved (rash). However, on 2/13/25, at 9:00 PM, this medication was not administered.

Resident #11 is prescribed Furosemide 40 mg tablet with orders to take one tablet by mouth daily for edema. However, on 2/7/25, at 8:00 AM, this medication was not administered.

Resident #11 was prescribed Mupirocin 2% ointment with orders to apply topically to affected area 3 times daily X 3 days from 2/21/25 to 2/24/25. However, this medication was not administered from 2/20/25 10:00 PM dose through 2/24/25 2:00 PM dose due to it not being available in the home.

Resident #8 is prescribed Alendronate Sodium 70 mg tab with order to have 1 tab with 8 oz H20 at least 30 minutes before food or drink 1 time weekly. However, this medication was not administered during the period between 2/1/25 and 2/10/25.

Resident #8 is prescribed Aspirin EC 81 mg, Atorvastatin 40 mg, Daily Vite, Januvia 100 mg tablet, Memantine HCL 10 mg tablet, Metformin HCL ER 500 mg tablet, and Vitamin B-12 1000 mcg tablet at 8:00 AM daily. However, these medications were not administered on 2/1/25 at 8:00 AM and 2/3/25 at 8:00 AM.

Resident #12 was prescribed IPRAT-ALBUT 0.5-3 2.6MG/3ML with orders to inhale 1 dose (3ML) via nebulizer 4 times a day for COPD with a discontinue date of 1/20/25. However, between 1/4/25 and 1/13/25, this medication was not administered due to the nebulizer machine was not working and the home waiting for new nebulizer machine.

Resident #12 was prescribed Ipratropium BR 0.02% SOLN; Inhale 1 ampule via nebulizer four times a day for COPD ordered to begin 1/20/25. However, between 1/20/25 and 1/31/25, this medication was not administered.

Resident #12 was prescribed Levalbuterol 1.25 MG/3ML SOL with orders to inhale 1 ampule via nebulizer four times a day for COPD to begin on 1/20/25. However, between 1/20/25 and 1/30/25, this medication was not administered.

Repeated Violation - 12/11/24, 5/30/24, et al.

Plan of Correction ***Accept (- 04/08/2025)***

Residents 1,11,8 and 12 no longer reside in the community.
-On 4/7/2025, physician notified of resident 9's missed doses on 2/13/25 by the Assistant Healthcare Director.
-By 4/11/2025, the Healthcare Director or designee/ pharmacy to audit medication carts and MARs. Medications not available, to be ordered and obtained.
-By 3/25/2025, the Healthcare Director or designee to educate associates who administer medications on regulation 2600.187d, documentation shall be kept.

187d - Follow Prescriber's Orders (continued)

-By 3/25/2025, the Healthcare Director or designee shall educate associates who administer medications to use the EMAR dashboard to ensure medications are administered as prescribed. Medication administration associates shall check the dashboard during medication administration times and at beginning and end of shift.
-Beginning 4/15/2025, the Healthcare Director or designee shall audit MARs weekly X 6 weeks for missed medications.
-To ensure consistent adherence to Regulation 2600.187d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

190a - Completion Medication Course

22. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department’s performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

According to training records, Staff person B was trained for medication administration by Staff Person O. However, Staff Person O is not certified as a train the trainer for medication administration. Staff Person O is only a practicum observer according to certificate. During the months of January and February, 2025, Staff Person B administered medications on the following dates to the following residents:

- *On 2/8/25, 2/10/25, 2/15/24, 2/20/25, and 2/24/25 to Resident # 1.*
- *On 2/2/25, 2/16/25, 2/17/25, 2/19/25, 2/24/25, 2/25/25 and 2/27/25 to Resident #10.*
- *On 2/2/25, 2/11/25, 2/13/25, 2/16/25, and 2/21/25 to Resident #9.*
- *On 2/2/25, 2/17/25, 2/24/25, 2/25/25, and 2/27/25 to Resident #11.*
- *On 1/10/25, 1/19/25, 1/22/25, 1/27/25, and 2/2/25 to Resident #7.*
- *On 2/7/25, 2/11/25, and 2/12/25 to Resident #8.*
- *On 2/5/25, 2/11/25, 2/13/25, and 2/21/25 to Resident #15.*

The home has documentation of Staff Member H being initially certified for medication administration on 11/21/19. However no further annual practicums or observations were provided for Staff Member H. During the months of December 2025 and February 2025, Staff Person H administered medications on the following dates to the following residents:

- *On 2/8/25, 2/9/25, 2/14/25, 2/22/25 and 2/23/25 to Resident #1.*
- *On 2/22/25 to Resident #9.*
- *On 2/8/25, 2/9/25, and 2/22/25 to Resident #8.*
- *On 12/14/24, 12/15/24, 12/28/24, and 12/29/24 to Resident #16.*

The home does not have documentation that Staff Person I has been initially certified for medication administration. However, during the month of February 2025, Staff Person I administered medication on the following dates to the following residents:

- *On 2/26/25 to Resident #9.*

190a - Completion Medication Course (continued)

- *On 2/26/25 for Resident #15.*

The home does not have documentation that Staff Person J has been initially certified for medication administration. However, Staff Person K administered medication on 2/20/25 to Resident #9.

The home does not have documentation that Staff Person K has been initially certified for medication administration. However, during the month of February 2025, Staff Person K administered medication on the following dates to the following residents:

- *On 2/8/25, 2/9/25, and 2/12/25 to Resident #9.*
- *On 2/18/25 to Resident #8.*

Plan of Correction ***Accept (- 04/08/2025)***

-Staff member B and J are no longer with the company.
-Staff member H has been removed from medication admin duties until retraining is completed ,currently enrolled in training class.
-Staff member I has been removed from medication admin duties until retraining is completed. initial certification completed 4/5/25.
-Staff member k has been removed by med admin duties, staff member is enrolled in med tech training class.
-By 3/15/2025, the Regional Healthcare shall educate the Healthcare Director and Assistant Healthcare Director on regulation 2600.190a. Documentation shall be kept.
-By 4/15/2025, the Healthcare Director or designee shall audit training documents of associates who administer medications. Associate without proper training documentation shall be retrained by a Train the Trainer by 4/30/2025.
-Beginning 4/21/2025, the Healthcare Director or designee shall review the med tech training documents monthly; observations shall be scheduled as needed.
---To ensure consistent adherence to Regulation 2600.190a, compliance monitoring will be conducted during the QMPI meeting. This review shall occur at the next QMPI meeting on 3/24/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *05/01/2025*

Implemented (- 05/30/2025)

Facility Information

Name: *LEGEND PERSONAL CARE AND MEMORY CARE OF LANCASTER* **License #**: *33306* **License Expiration**: *07/09/2025*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA 17603*

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

Administrator

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

Legal Entity

Name: *LANCASTER PCH LLC*

Address: *31 MILLERSVILLE ROAD, LANCASTER, PA, 17603*

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *12/11/2004* **Issued By**: *Manor Township*

Type: *I-2* **Date**: *12/11/2004* **Issued By**: *Manor Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *112* **Waking Staff**: *84*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *04/17/2025*

Inspection Dates and Department Representative

04/16/2025 - On-Site: [redacted]

04/17/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *79*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Memory Care* **Capacity**: *33* **Residents Served**: *30*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *79*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *33* **Have Physical Disability**: *0*

Inspections / Reviews

04/16/2025 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/19/2025*

Inspections / Reviews *(continued)*

05/21/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *05/22/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *05/28/2025*

05/23/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *05/22/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *06/16/2025*

16c - Written Incident Report

1. 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 4/2/25, at approximately 5:47 PM, staff member A and staff member B were in the hallway walking resident #2's room. Staff members A and B heard a slap sound and then heard resident #2 sounding like [redacted] was crying. Staff members A and B overheard staff member C state, "I did not hit you that hard." The home did not report this incident to the Department until 4/8/25 at 1:07 PM.

On 4/6/25, resident #1 eloped from the home's Secured Dementia Care Unit and was found by police at approximately 9:00 PM. The resident was found approximately 5.5. miles away from the home, walking along Route 30 near Prospect Road in Columbia. However, this was not reported to the Department until 4/8/25 at 3:15 PM.

Repeated Violation - 5/30/24, et al and 4/9/24, et al

Plan of Correction ***Do Not Accept ([redacted] - 05/21/2025)***

-Unable to correct; written incident report for incident on 4/2/25 and incident on 4/6/25 were reported late to the department.
-On 4/6/2025 RDO provided education to Administrator on reportable incidents and provided the correct email to send incidents and regulation 2600.16c. Documentation shall be kept.
-By 5/1/2025, the administrator shall review previous 30 days of incidents to ensure required written incident reports have been submitted to the correct governing agency.
-Beginning 5/1/2025, the administrator or healthcare director shall review incidents as needed to ensure timely reporting; this review will occur as needed weekly and continue for 4 weeks.
- To ensure consistent adherence to Regulation 2600.16c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Update: *05/21/2025*

- Incidents should be reviewed daily, not weekly as the timeframe to report an incident to the Department is within 24 hours.

Plan of Correction ***Accept ([redacted] - 05/23/2025)***

-Unable to correct; written incident report for incident on 4/2/25 and incident on 4/6/25 were reported late to the department.
-On 4/6/2025 RDO provided education to Administrator on reportable incidents and provided the correct email to send incidents and regulation 2600.16c. Documentation shall be kept.
-By 5/1/2025, the administrator shall review previous 30 days of incidents to ensure required written incident reports have been submitted to the correct governing agency.
-Beginning 5/1/2025, the administrator or healthcare director shall review incidents as needed to ensure timely reporting; this review will occur daily and continue for 4 weeks.

16c - Written Incident Report (continued)

- To ensure consistent adherence to Regulation 2600.16c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

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

Resident #1 was initially admitted to the home under personal care on [redacted] but was moved to the home's Secure Dementia Care Unit (SDCU) after the resident attempted to leave the home three times on [redacted] Following the resident's move to the SDCU, the resident had been observed multiple times by staff trying to leave the SDCU through the dining room door that led to the outside of the building. On 4/6/25, at approximately 9:00 PM, resident #1 was found by police walking along Route 30 near Prospect Road in Columbia, which is approximately 5.5 miles away from the home. The home was unaware the resident had been missing until police contacted the home, at approximately 10:30 PM, stating the resident had been found. Staff member D, who was on shift the evening of 4/6/25, stated [redacted] did not include the resident in [redacted] 9:00 PM to 9:30 PM rounds. Staff member E, who received the call from police that evening, reported there was no way the aides working that evening included the resident in their 8:00 PM to 8:30 PM rounds. On 4/17/25, agents of the Department inspected the door in the SDCU that the resident has used in attempting to leave the home. The agents of the Department observed this door did not completely latch close.

On 4/13/25, at approximately 9:05 PM, in the SDCU, staff discovered resident #6 in the apartment of resident #4. Both residents were undressed, and resident #4 [redacted] resident #6. The residents were separated. Resident #6 was taken back to [redacted] room. Both residents' have a diagnosis of Dementia and have a need to reside in SDCU. There is no indication in either resident #4 or resident #6's records indicating their ability to consent to sexual contact, and the home has not had either resident evaluated by a medical professional to determine the residents' ability to consent.

Repeated Violation - 10/3/24, et al

Plan of Correction ***Do Not Accept ([redacted] - 05/21/2025)***

- Resident 1 was assessed by the med tech on duty on 4/6/2025, no injuries noted , support plan updated with incident and interventions. Staff on duty performed head count and all residents were present and accounted for.
-On 4/13/2025 Resident 4 and resident 6 were assessed by med tech on duty , no injuries noted. Both responsible parties and physicians notified. Resident 4 and resident 6 support plans updated to reflect the incident and interventions.
-On 4/21/2025, the administrator conducted an elopement drill.
-By 4/10/2025 the administrator shall educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.
-By 5/29/2025 the administrator shall re-educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.
-Beginning 5/16/2025 the administrator shall interview 5 residents weekly X 4 weeks to ensure safety and needs

42b - Abuse (continued)

are being met.
- To ensure consistent adherence to Regulation 2600.42b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Update: *05/21/2025*

- Provide a step for fixing the door regarding Resident #1's elopement. Provide date this will be done by and person(s) responsible.

Plan of Correction ***Accept (█ - 05/23/2025)***

- Resident 1 was assessed by the med tech on duty on 4/6/2025, no injuries noted , support plan updated with incident and interventions. Staff on duty performed head count and all residents were present and accounted for.
-On 4/13/2025 Resident 4 and resident 6 were assessed by med tech on duty , no injuries noted. Both responsible parties and physicians notified. Resident 4 and resident 6 support plans updated to reflect the incident and interventions.
-On 4/21/2025, the administrator conducted an elopement drill.
-By 4/10/2025 the administrator shall educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.
-On 4/21/2025, the maintenance director checked the outside exit door to ensure proper operation and tightened the latch.
-By 5/29/2025 the administrator shall re-educate current staff on elopement, abuse and regulation 2600.42b. Documentation shall be kept.
-Beginning 5/16/2025 the administrator shall interview 5 residents weekly X 4 weeks to ensure safety and needs are being met.
- To ensure consistent adherence to Regulation 2600.42b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

82c - Locking Poisonous Materials

3. Requirements

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

Description of Violation

On 4/17/25, at approximately 10:15 AM, a Dove Advanced Care Deodorant stick with a manufacturer's label indicating "If swallowed, get medical help or contact a Poison Control Center right away," and a bottle of Eucerin Itch Relief Intensive Calming Lotion with a warning label stating, "Keep out of reach of children, get medical help or contact a Poison Control Center right away" were unlocked, unattended, and accessible in resident #1 and resident #3's shared room. Not all the residents of the home, including Resident #1 and Resident #3, have been assessed capable of recognizing and using poisons safely.

82c - Locking Poisonous Materials (continued)

On 4/17/25, at approximately 10:20 AM, two containers of Clorox disinfecting wipes with a manufacturer's label stating, "call a poison control center for treatment advice" was unlocked, unattended, and accessible in resident #4's room. Not all the residents of the home, including resident #4, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/17/25, day of survey, the administrator secured the Dove Advanced Care Deodorant Stick and the bottle of Eucerin Itch Relief Intensive Calming Lotion from resident 1 and resident 3's shared room. The Clorox Disinfecting Wipes were removed resident 4's room.
-On 4/18/2025, the administrator audited remaining memory care apartments for compliance with regulation 2600.82c. Any further findings corrected at time of audit.
-By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.82c, documentation shall be kept.
-Beginning 5/16/2005, the administrator or designee shall audit 5 memory care apartments daily on work days X 4 weeks to ensure compliance with regulation.
-- To ensure consistent adherence to Regulation 2600.82c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability

Licensee's Proposed Overall Completion Date: *06/16/2025*

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 4/17/25, at approximately 10:57 AM, a portable urinal was hanging on the toilet grip bar in resident #2's room. The urinal had feces caked around the rim. The toilet had feces splatter around the inside of the toilet as well as on the toilet seat. Also, the bathroom trash can had feces on the edge of the lid.

Plan of Correction ***Accept (█ - 05/21/2025)***

-On 4/17/25, at time of survey, resident 2's bathroom including the urinal and trashcan were cleaned by the housekeeper.
-On 4/18/2025 , the maintenance director or designee audited remaining bathrooms for cleanliness, any further findings corrected at time of audit.
-By 5/29/2025 , the administrator or designee to educate current staff on regulation 2600.85a, documentation

85a - Sanitary Conditions (continued)

shall be kept.
-Beginning 5/16/2005, the administrator or designee shall observe 5 bathrooms weekly X 4 weeks to ensure adherence to regulation.
- To ensure consistent adherence to Regulation 2600.85a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Withdrawn **6/3/25**

121a - Unobstructed Egress

6. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

The door in the Secure Dementia Care Unit (SDCU) adjacent to resident room #311 has a code box. On 4/17/25, at approximately 9:55 AM, the code box was not functioning, and the push bar did not open the door, preventing immediate egress.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Accept (- 05/21/2025)***

- The lock on the egress door outside of room 311 disengages when the alarm is sounding as evidenced during the monthly fire drills.
-4/18/2025, Maintenace Director contacted the alarm company to correct the code box, the alarm company is expected at the home 5/20/2025.
-On 4/18/2025 the maintenance director or designee tested remaining secure doors for proper functioning.
-By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.121a and the process for communication if keypads are not functioning, documentation shall be kept.
-Beginning 4/18/2025, the administrator or designee shall test secure memory care doors weekly X 4 weeks.
- To ensure consistent adherence to Regulation 2600.121a, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

144c1 - Smoking Area Guidelines

7. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

1. Proper safeguards inside and outside of the home to prevent fire hazards involved in smoking, including providing fireproof receptacles and ashtrays, direct outside ventilation, no interior ventilation from the smoking room through other parts of the home, extinguishing procedures, fire resistant furniture both inside and outside the home and fire extinguishers in the smoking rooms.

Description of Violation

The home's designated smoking area is at the delivery entrance area. On 4/17/25, at approximately 10:00 AM, numerous cigarette butts were observed outside the exit door of the Secure Dementia Care Unit located by the dumpsters.

On 4/17/25, at 1:05 PM, resident #5 was observed sitting on walker smoking a pipe in the center courtyard.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/17/2025 at the time of the incident, Administrator and a representative from DHS meet with resident 5 and provided verbal education.
-On 4/18/2025, the administrator or designee removed the cigarette butts from the area outside the exit of the SDU by the dumpsters.
- By 4/21/2025, the administrator or designee to inspect remaining outside areas for cigarette butts, further findings addressed at time of audit.
-By 5/29/2025, the administrator or designee to educate current staff on smoking area, company smoking policy and regulation 2600.144c1. Documentation shall be kept.
-On 5/6/2025, the administrator spoke with resident 5 and had resident re-sign the smoking policy.
-Beginning 4/29/2025, the administrator or designee shall observe outside areas 3 X weekly X 4 weeks for compliance with 2600.144c1.
- To ensure consistent adherence to Regulation 2600.144c1, compliance monitoring will be conducted during the

144c1 - Smoking Area Guidelines (continued)

QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

183b - Meds and Syringes Locked

8. 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 4/17/25, at approximately 10:14 AM, two tubes of Zinc Oxide Paste Skin Protectant were unlocked, unattended, and accessible in resident #1's and resident #3's shared room in the Secure Dementia Care Unit.

On 4/17/25, at approximately 10:56 AM, Ketoconazole cream 2%, Halls cough drops, and Lidocaine Hemp Pain Relief cream were unlocked, unattended and accessible in resident #2's room.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/17/25, at time of survey, the healthcare director removed 2 tubes of Zinc Oxide Paste Skin Protectant from the shared room of resident 1 and resident 3.
-On 4/17/25, at time of survey, the healthcare director removed Ketoconazole cream 2%, Halls Cough drops and Lidocaine Hemp Pain Relief cream from resident 2's room.
-By 4/18/2025, the healthcare director or designee, audited remaining apartments for compliance to regulation, any further findings corrected at time of audit.
-By 5/29/2025, the administrator or designee shall educate current staff on regulation 2600.183b and to report noncompliant findings to Healthcare Director or designee, documentation shall be kept.
-Beginning 5/16/2025, the administrator or designee shall audit 5 memory care apartments and 5 personal care apartments for adherence with regulation. This audit shall occur weekly X 4 weeks.
--To ensure consistent adherence to Regulation 2600.183b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Withdrawn **6/5/25**

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

. **Withdrawn** **6/5/25**

Resident #4's most recent assessment was on

Plan of Correction ***Do Not Accept (- 05/21/2025)***

-On 4/17/2025, the healthcare director completed an assessment/support plan for resident 4.
-By 4/21/2025, the healthcare director or designee to audit current resident support plans for accuracy and timely completion.
-By 4/21/2025, the administrator shall educate the healthcare director on regulation 2600.225c. Documentation

225c - Additional Assessment (continued)

shall be kept.
-Beginning 4/21/2025, the administrator or designee shall audit new assessments for accuracy and timely completion weekly X 4 weeks.
- To ensure consistent adherence to Regulation 2600.225c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

Update: *05/21/2025*

- The audit completed on 4/21/25 states "support plans". It should reflect assessments as well because that is what the violation was cited for.

Plan of Correction ***Accept (- 05/23/2025)***

-On 4/17/2025, the healthcare director completed an assessment/support plan for resident 4.
-By 4/21/2025, the healthcare director or designee to audit current resident assessments and support plans for accuracy and timely completion.
-By 4/21/2025, the administrator shall educate the healthcare director on regulation 2600.225c. Documentation shall be kept.
-Beginning 4/21/2025, the administrator or designee shall audit new assessments and support plans for accuracy and timely completion weekly X 4 weeks.
- To ensure consistent adherence to Regulation 2600.225c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

233c - Key-Locking Devices

11. 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 4/17/25, at approximately 9:50 AM, the directions for operating the home's locking mechanism were not conspicuously posted near the door adjacent to resident room #311 in the Secure Dementia Care Unit.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/17/25, at time of survey, the maintenance director conspicuously posted the operating directions (code) for the locking mechanism at the door adjacent to resident room 311.
-On 4/21/2025, the maintenance director audited remaining locking mechanisms, any further findings shall be addressed at time of audit.
-By 4/21/2025, the administrator shall educate the maintenance director on regulation 2600.233c, documentation

233c - Key-Locking Devices (continued)

shall be kept.
-By 5/29/25, the administrator shall educate current staff on regulation 2600.233c, documentation shall be kept.
-Beginning 4/21/2025, the administrator or designee shall audit key locking devices weekly X 4 weeks. Per TELS the maintenance director shall check functioning of locking devices/ placement of operating directions monthly, ongoing.
- To ensure consistent adherence to Regulation 2600.233c, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

233d - Electronic/Magnetic System

12. Requirements

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

There is a door beside the kitchenette in the Secure Dementia Care Unit that exits to outside of the home. On the morning of 4/17/25, this door only latched closed three out of five times. On the afternoon of 4/17/25, this door only latched closed one out of four times.

Plan of Correction ***Accept (- 05/21/2025)***

-On 4/18/2025 the maintenance director adjusted the memory care door beside the kitchenette to ensure proper closure/latching.
-On 4/21/2025, the maintenance director checked the remaining outside exit doors to ensure proper operation.
-By 4/21/2025 the administrator shall educate the maintenance director on regulation 2600.233d, documentation shall be kept.
-Beginning 4/21/2025, the administrator or designee shall observe the outside exit doors weekly X4 weeks for proper closure.
-Beginning 5/19/25, per TEL's the Maintenace director shall observe exit doors for proper functioning monthly during building rounds.
- To ensure consistent adherence to Regulation 2600.233d, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025, documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*

251b - Record Entries Legible

13. Requirements

2600.
251.b. The entries in a resident’s record must be permanent, legible, dated and signed by the staff person making the entry.

251b - Record Entries Legible *(continued)*

Description of Violation

Correction tape was used on resident #1's preadmission screening, dated [redacted] the resident's assessment and support plan addendum, dated [redacted], and the resident's progress notes from 3/3/25.

Plan of Correction ***Accept ([redacted] - 05/21/2025)***

-Unable to correct documentation on resident 1's chart.
-By 5/29/2025, the administrator shall educate current staff on 2600.251b, documentation shall be kept.
-Beginning 4/21/2025, the administrator or designee shall audit 5 charts weekly X 4 weeks to ensure adherence to regulation.
- To ensure consistent adherence to Regulation 2600.251b, compliance monitoring will be conducted during the QMPI meeting. This review, shall occur at the next QMPI meeting on 5/19/2025 documentation shall be kept, further ensuring our commitment to transparency and accountability.

Licensee's Proposed Overall Completion Date: *06/16/2025*