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

August 21, 2025

[redacted]
WILLIAMSPORT AID II OPCO LLC
[redacted]

RE: LEIGHTON PLACE
1251 RURAL AVENUE
WILLIAMSPORT, PA, 17701
LICENSE/COC#: 22660

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LEIGHTON PLACE* **License #**: *22660* **License Expiration**: *05/15/2026*

Address: *1251 RURAL AVENUE, WILLIAMSPORT, PA 17701*

County: *LYCOMING* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *WILLIAMSPORT AID II OPCO LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/02/2002* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *25* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *07/16/2025*

Inspection Dates and Department Representative

07/16/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *65* **Residents Served**: *37*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*

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

Have Mobility Need: *9* **Have Physical Disability**: *0*

Inspections / Reviews

07/16/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/08/2025*

08/13/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/14/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/20/2025*

Inspections / Reviews *(continued)*

08/14/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/21/2025*

08/21/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2025*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

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

The home failed to file an incident report to the department for resident [redacted]s fall that occurred on 7/14/25 and resulted in multiple rib fractures.

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

1. Immediate Corrective Actions
Upon recognition of the missed reporting requirement, the incident involving Resident 1 was immediately reported retroactively to the Department's regional office on July 16th, 2025, along with an explanation for the delay.

The incident documentation, including internal investigation, treatment, and follow-up actions, has been reviewed for completeness and filed appropriately.

2. Root Cause Analysis
An internal review determined that the missed report was due to a failure in the communication chain between care staff and the administrator responsible for reporting to the Department.

It was also identified that reporting procedures were not consistently followed or reinforced with all staff, contributing to the oversight.

3. Policy and Procedure Enhancement
The Incident Reporting Policy was revised on [Insert Date] to clearly outline:

The types of incidents that must be reported (including serious injuries such as fractures from falls).

The 24-hour timeframe for reporting to the Department.

The process for documentation, internal notification, and follow-up.

A designated "Critical Incident Checklist" was created and implemented to ensure proper steps and timelines are followed in real time.

4. Staff Training and Accountability
All staff, including caregivers, shift supervisors, and administrators, participated in mandatory retraining on 7/31/2025. focused on:

Recognizing and escalating reportable incidents.

State reporting timelines and procedures (including § 2600.16 and § 2600.15).

Use of the new "Critical Incident Checklist."

16c Written Incident Report (continued)

A post training quiz was administered to verify understanding, and all staff members signed an acknowledgment of receipt and comprehension of the new protocol.

5. Designation of Responsibility
A primary and secondary Incident Reporting Coordinator were designated to ensure backup coverage in case the primary staff member is unavailable.

The Executive Director or designee will be notified immediately upon occurrence of any incident that may require reporting, regardless of time or day.
At the time of Resident 1's fall on 7/16/2025, staff responded immediately and appropriately by assessing the resident and arranging for [redacted] to be transported to the hospital due to concerns of head trauma. Based on the initial presentation and symptoms, there was no indication at the time of the fall that rib fractures had occurred.

The facility did not submit an immediate incident report to the Department because the full extent of the resident's injuries specifically, the rib fractures was not known until after [redacted] returned from the hospital and [redacted] medical records were reviewed. Once hospital documentation confirming the fractures was received, the incident was assessed as meeting the criteria for reportable incidents under § 2600.16(c), and the report was subsequently filed.
1. Immediate Corrective Actions Taken
On 7/16/2025, immediately following Resident 1's fall, staff assessed the resident and arranged for transport to the hospital due to head impact.

At the time of transfer, there were no signs or symptoms indicating rib injury, and thus the incident did not meet reporting criteria under § 2600.16(c).

Following the resident's return to the community and upon receipt of hospital documentation indicating multiple rib fractures, the incident was then identified as reportable, and the Department was notified accordingly on 7/16/2025.

The delay in reporting was not due to oversight but rather due to the timing of confirmed diagnosis.

6. Quality Assurance and Monitoring
A standing agenda item has been added to the facility's monthly Quality Assurance (QA) meetings to review all incident reports and ensure:
Timeliness of external reporting.

Proper documentation and follow up.

A random monthly audit of incident records (minimum 10%) will be conducted by the QA Coordinator to verify reporting compliance.

7. Communication with Resident and Family
Resident 1's family was promptly notified of the injury and care actions.

They have also been informed of the additional internal steps taken to improve reporting processes moving forward.

16c - Written Incident Report (continued)

Completion Date of Plan Implementation
All corrective actions will be fully implemented by 8/15/2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented (- 08/14/2025)

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 has a diagnosis of and utilizes a wander guard in the home. Through staff interviews it was determined that Resident and Resident are allowed to be alone together in their bedrooms and that Resident refers to Resident as spouse which they are not. Resident was interviewed by the Licensing Representative and was confused and at times referred to resident as their spouse and later indicating that they were a friend. The Resident Assessment and Support Plan dated 5/16/2025 for Resident indicates that they have severe impairment with both short-term and long-term memory and will make unsafe or inappropriate decisions.
Resident indicated that they are in an intimate relationship with Resident and will lie together while naked in bed. Staff indicated that residents & are allowed in each other's room with the doors closed. Due to Resident s confusion and diagnosis of dementia, they are unable to consent to a sexual relationship.

Plan of Correction ***Directed - 08/14/2025)***

Executive Director Statement of Circumstances and Actions Taken
At no time did I, as Executive Director, give permission for the two residents in question to be alone together in a resident room with the door closed. Upon discovering that the residents were engaging in unsupervised, closed-door visits, I immediately intervened and began an internal review of the situation.

Upon further inquiry, I discovered that the residents had developed a friendship and emotional connection. While they had been spending time together privately, there was no indication of sexual activity or any inappropriate behavior. Both residents are known to be deeply religious and expressed that they were simply seeking companionship and emotional support. Both residents described the relationship as non-romantic and non-sexual in nature.

I promptly notified both residents' Powers of Attorney (POAs) and informed them of the nature of the relationship and the unsupervised time spent together. In response, I facilitated a care conference/meeting with both residents and their respective POAs to openly discuss the matter. During the meeting: on 06/03/2025,

Families expressed support for the residents' friendship.

All parties acknowledged that the relationship was non-sexual.

Residents confirmed they valued the companionship and had no intent to violate community rules or expectations.

To ensure appropriate boundaries and continued resident safety:

42b - Abuse (continued)

Staff were instructed to monitor interactions between the residents, particularly to ensure doors remain open during visits.

The situation was documented in both residents' charts.

Staff were reminded of the policy regarding resident privacy, supervision, and appropriate documentation of interpersonal relationships that may impact care or supervision needs.

This matter was handled with respect for residents' rights, dignity, and the safety of all parties involved, and future interactions will continue to be monitored to ensure compliance with all policies and regulatory standards.

Proposed Overall Completion Date: 08/13/2025

Directed: In addition to the above plan of correction, the administrator or designee will develop a supervision plan that does not allow Resident [redacted] or Resident [redacted] to be in each others room. All contact between Resident [redacted] & [redacted] will be in common areas of the home and supervised by staff due to Resident [redacted] inability to consent to an intimate relationship. Staff will be educated regarding the supervision needs of Resident [redacted] & [redacted] and that they are only to meet in common areas of the home.

Directed Completion Date: *08/21/2025*

Implemented [redacted] - 08/21/2025)

225c - Additional Assessment

3. Requirements

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

Description of Violation

Resident [redacted] assessment, dated [redacted], does not include their use of a Wander Guard.

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

1. Immediate Corrective Actions
On July 18th, Resident [redacted] assessment was revised and updated to accurately include the use of a Wander Guard.

The resident's Support Plan was also amended to reflect the purpose of the Wander Guard and ensure it aligns with the current risk for elopement and safety supervision needs.

2. Root Cause Analysis
Upon review, it was determined that the assessment form in use lacked a designated prompt or checkbox for safety devices such as Wander Guards, contributing to staff oversight.

Additionally, the reviewing staff member did not verify the presence of all assistive and monitoring devices when completing the assessment.

3. Policy and Form Revision

225c - Additional Assessment (continued)

On July 18th, the facility's Resident Assessment Form was revised to include a dedicated section titled "Use of Safety Devices", with specific checkboxes for:

Wander Guard

Bed/chair alarms

Mobility assistance devices

Other safety/supportive equipment

The Assessment Policy was updated to require that all assessments be completed with direct verification of safety devices currently in use, in coordination with direct care staff and clinical documentation.

4. Staff Training
On July 31st, 2025, all staff responsible for resident assessments (including nurses and case managers) received a mandatory in-service training on:

Regulatory requirements under § 2600.225(c)

How and when to assess for and document the use of Wander Guards and other safety equipment

Use of the revised assessment forms and documentation standards

All attendees completed a post-training knowledge check, and attendance records have been filed.

5. Quality Assurance and Ongoing Monitoring
Effective July 31st, the Wellness Director or designee will review all newly completed or updated resident assessments to ensure that safety devices, including Wander Guards, are properly documented.

A quarterly audit of 10% of all active resident records will be conducted by the QA Coordinator to ensure continued compliance and accuracy in assessments and support plans.

Any discrepancies found during audits will be immediately corrected, and responsible staff will receive targeted retraining.

6. Designation of Responsibility
Executive Director – Ensures full implementation and compliance oversight.

Wellness Director – Oversees accurate assessment completion and staff adherence to updated policy.

QA Coordinator – Conducts ongoing audits and reports findings to the management team monthly.

Completion Date of Full Plan Implementation
All corrective actions will be fully implemented by 8/15/2025.

225c Additional Assessment *(continued)*

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/14/2025)

227c - Support Plan Revision

4. Requirements

2600.
227.c. The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

Description of Violation

Residents [redacted] Assessment and Support Plan (RASP) dated [redacted], Resident [redacted]s RASP dated [redacted], and Resident [redacted] RASP dated [redacted] do not have dates to indicate when the Support Plan was finalized.

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

1. Immediate Corrective Actions Taken
As of 7/17/2025, the Support Plans for Residents [redacted] and [redacted] have been updated to include the finalization date. These dates have been verified to confirm compliance within the 30 day timeframe post assessment.

A quality assurance review was conducted for all current residents to identify and correct any other missing finalization dates in Support Plans.

2. Policy and Procedure Revision
The facility's RASP Completion and Documentation Policy was revised on July 17th, 2025, to include the following mandatory steps:

The staff member responsible for completing the Support Plan must document the date of finalization on the plan.

The finalization date must be clearly visible and labeled on the signature line or immediately adjacent to the final approval signature.

A secondary review will be conducted by the Wellness Director or designee to ensure compliance before filing the RASP in the resident's chart.

3. Staff Training
On July 21st, all clinical and administrative staff involved in assessments and support planning (including RNs, LPNs, Care Coordinators, and Case Managers) received mandatory in service training covering:

Regulation 2600.227(c) requirements

Proper documentation of finalization dates on Support Plans

Timelines for RASP revision following annual assessments or changes in resident condition

Training sign in sheets and materials have been filed and are available upon request.

4. Ongoing Monitoring

227c Support Plan Revision (continued)

Beginning 7/18/2025, the Quality Assurance Coordinator will conduct monthly audits of 25% of RASPs to ensure that:

The support plan includes a documented date of finalization.

The support plan was completed and finalized within 30 days of the assessment.

Audit results will be reported during monthly QA meetings and corrective actions taken immediately for any non compliance.

5. Responsible Personnel
Executive Director Overall responsibility for implementation and oversight of the plan.

Wellness Director Ensures assessments and support plans are completed within timeframes and properly documented.

Quality Assurance Coordinator Performs ongoing audits and provides feedback to staff and management.

Completion Date of Full Plan Implementation
All corrective measures will be fully implemented by 8/18/2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented [redacted] - 08/21/2025)

227h - Support Plan Refuse Sign

5. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [redacted] did not sign their support plan dated [redacted] and there was no notation that the resident refused to sign, was unable to participate, or was unable to sign.

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

Regulation Cited:
2600.227.h If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Violation Description:
Resident [redacted] did not sign their support plan dated [redacted], and there was no notation indicating refusal or inability to sign.

Corrective Action for the Specific Violation

227h Support Plan Refuse Sign (continued)

The support plan for Resident [redacted] dated 5/16/25 was immediately reviewed.

A notation has now been added to the resident's support plan stating: "Resident refused to sign the support plan on 5/16/25."

The plan was re reviewed with the resident on 7/18/2025, and their right to participate or decline to sign was explained.

Corrective Action for All Other Residents,

A complete audit of all current resident support plans was conducted on July 21st.

Any instances where signatures were missing without notation were corrected, with appropriate documentation added.

Staff responsible for care plan reviews were interviewed to determine understanding of 2600.227.h.

Systemic Changes to Prevent Recurrence

A mandatory in service training was held on July 31st, 2025 for all staff responsible for developing and reviewing support plans.

Training covered:

Regulatory requirements under 2600.227.h

Documentation of refusal or inability to sign

Proper resident engagement practices

A support plan review checklist has been implemented to include a section verifying:

Resident or designated person signature

Or clear notation if they refuse or are unable to sign

Monitoring and Quality Assurance

The Administrator or designee will review all completed support plans weekly for 60 days to ensure compliance with 2600.227.h.

After 60 days, support plans will be audited monthly for 6 months, and findings will be reported at the facility's QA meetings.

Non compliance will result in immediate retraining and corrective action.

227h Support Plan Refuse Sign (continued)

Completion Date of Corrective Actions

All corrective actions will be completed by: August 15th, 2025.

Licensee's Proposed Overall Completion Date: *07/31/2025*

Implemented ([redacted] - 08/20/2025)