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

September 30, 2025

[redacted] DIRECTOR OF PERSONAL CARE/ADMINISTRATOR
UNITED ZION RETIREMENT COMMUNITY, INC.
722 FURNACE HILLS PIKE
LITITZ, PA, 17543

RE: UNITED ZION RETIREMENT COMMUNITY
722 FURNACE HILLS PIKE
LITITZ, PA, 17543
LICENSE/COC#: 32181

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/28/2025 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: *UNITED ZION RETIREMENT COMMUNITY* **License #**: *32181* **License Expiration**: *08/15/2026*

Address: *722 FURNACE HILLS PIKE, LITITZ, PA 17543*

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

Administrator

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

Legal Entity

Name: *UNITED ZION RETIREMENT COMMUNITY, INC.*

Address: *722 FURNACE HILLS PIKE, LITITZ, PA, 17543*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/22/1995* **Issued By**: *Department of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *28* **Waking Staff**: *21*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *08/28/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *49* **Residents Served**: *25*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *25*

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

Have Mobility Need: *3* **Have Physical Disability**: *1*

Inspections / Reviews

08/28/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/22/2025*

09/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/29/2025*

Inspections / Reviews *(continued)*

09/26/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/30/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/03/2025*

09/30/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/30/2025*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 9/23/16, requires the battery of battery operated carbon monoxide alarms be labeled with the date of of installation and replaced at least once annually. On 8/28/25 at 11:30 AM, the carbon monoxide alarm located in the kitchen was not labeled with the date of battery installation.

Plan of Correction ***Accept (- 09/26/2025)***

The director of Facilities has placed a new and dated battery in the carbon monoxide detector on 8/28/2025. This will be monitored annually by the facilities director.

*** 9/26/25- Direct education was given by PCHA to Facilities Director on date of inspection. initiated the annual audit on 08/28/2025 when new and labelled battery was placed. This carbon monoxide detector is the only battery operated one in the facility- all others are hard wired. Start date of annual monitoring was date of inspection 08/28/2025.*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 09/30/2025)

65d - Initial Direct Care Training

2. Requirements

2600.
65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:
2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Staff member A, hired on began providing unsupervised ADL services on However, the staff member did not complete and pass the Department-approved direct care training course and pass the competency test until

Plan of Correction ***Accept (- 09/26/2025)***

PCHA will do a staff audit prior to completion of supervised training to ensure that all necessary documents are obtained. Any employees with outstanding documents will not be permitted to work unsupervised until they are received by PCHA. Audit form to be attached to new hire training documents. This audit form has gone into effect as of 09/01/2025 for all new hires.

*** 9/26/25- PCHA conducted an audit on all staff files to ensure that all items are present and meeting regulatory guidelines on 09/01/2025. PCHA is responsible for ensuring all state required documents are obtained and completed prior to completion of initial staff training period, and bi-annually. Attached is audit form created and used.*

Proposed Overall Completion Date: 09/26/2025

Licensee's Proposed Overall Completion Date: *09/26/2025*

65d - Initial Direct Care Training *(continued)*

Implemented ([redacted] - 09/30/2025)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Staff member B, hired on [redacted] did not receive training in medication self-administration and instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during training year 2024.

Repeated Violation - 8/29/24

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA has reviewed staff members file on 08/29/2025. Staff member had completed state required annual training in 07/2025 and all team members are to complete training annually with PCHA. Quarterly audits will be completed on all staff members to ensure compliance with trainings. Audits were in place on 09/01/2025. At present all active team members are in compliance.

*** 09/26/2025- PCHA is the staff member responsible for ensuring compliance with regulations. PCHA reviewed regulations on date of survey and begun an audit on all team members files to ensure training was completed for all staff. No other team member was out of compliance. Quarterly audits on staff records is to be completed by PCHA.*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

65g - Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff member B, hired on [redacted], did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert during training year 2024.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA has reviewed staff members file on 08/29/2025. Staff member had completed state required annual training in 07/2025 and all team members are to complete training annually with PCHA. Quarterly audits will be

65g - Annual Training Content (continued)

completed on all staff members to ensure compliance with trainings. Audits were in place on 09/01/2025. At present all active team members are in compliance.

*** 09/26/2025- PCHA is the staff member responsible for ensuring compliance with regulations. PCHA reviewed regulations on date of survey and begun an audit on all team members files to ensure training was completed for all staff. No other team member was out of compliance. Quarterly audits on staff records is to be completed by PCHA.*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

91 - Telephone Numbers

5. 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 were no emergency telephone numbers to include the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline on or by the telephone in the kitchen.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA placed all required phone numbers in kitchenette on 08/29/2025.

*** 09/26/2025- PCHA is responsible for ensuring item is in place. This is the only other accessible outside line in Personal Care for residents or staff usage.*
PCHA will conduct quarterly environmental audits to ensure compliance beginning on 09/01/2025

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

103e - Left Overs

6. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

On 8/28/25 at 9:30 AM, there was an unlabeled, undated Tupperware container containing cantaloupe and an unlabeled, undated takeout box containing food items in the mini-fridge of the first floor kitchenette.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA removed and discarded unlabeled items at time of inspection on 08/28/25. All residents were reminded to label and date stored items on 08/29/2025 and team members were verbally educated on discarding unlabeled items during their nightly temperature checks. This education was provided on 08/29/2025.

103e - Left Overs (continued)

*** PCHA has included checking of refrigerators to quarterly environmental audits to ensure compliance that will be completed by PCHA (Directed)* ***Quarterly audits by will begin no later than 10/1/25-*** [redacted]

Proposed Overall Completion Date: 09/26/2025

Licensee's Proposed Overall Completion Date: *10/01/2025*

Implemented ([redacted] - 09/30/2025)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 8/28/25 at 10:45 AM, the temperature in the refrigerator located in the back of the personal care kitchen was 42 degrees Fahrenheit and at 3:14 PM it was 42.3 degrees Fahrenheit.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA notified Facilites department of the refrigerator failing to keep adequate temperature on 08/28/2025. All food items were removed until refrigerator issue was resolved and held temperature on 08/29/2025

***9/26/2025- PCHA has added refrigerator temperature checks to quarterly environmental rounding completed by PCHA beginning on 09/01/2025. PCHA is responsible for ensuring temperatures remain in compliance*

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

184a - Resident's Meds Labeled

8. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The pharmacy label for resident #1's Dicyclomine, Acetaminophen, Amlodopine, and Cetirizine medications did not include the prescribed dosage and instructions for administration.

The Insulin Gargline and Humulin pens for resident #2 did not include a pharmacy label that included the prescribed dosage, instructions for administration and the name and title of the prescriber.

On 8/28/25, the pharmacy label for resident #2's Humulin KwikPen included instructions to inject 5 units under the skin 3 times daily (with meals) unless sugar is less than 110. However, the current prescriber's order stated to inject 5 units subcutaneously three times daily; hold for BS< 100.

184a - Resident's Meds Labeled (continued)

Repeated Violation - 8/29/2024

Plan of Correction ***Accept (- 09/26/2025)***

PCHA contacted house pharmacy with request to change our medication packets to include full dosage and administration details. Pharmacy made correction to all medication packets on 09/08/2025. All pharmacy labels are in compliance as of 09/08/2025.

***9/26/2025- Audit was completed on all residents medications on 09/09/2025 when new packets were delivered from pharmacy and all residents are currently meeting regulations.*
During monthly cart audits performed by LPN Supervisor will ensure compliance. Cart audit was completed on 09/09/2025 by LPN supervisor.
Education provided to LPN supervisor verbally to ensure we are closely monitoring compliance and to report any failures to PCHA. ***(Directed) Education to be provided to LPN supervisor no later than 10/1/25-***

Licensee's Proposed Overall Completion Date: *10/01/2025*

Implemented (- 09/30/2025)

225c - Additional Assessment

9. Requirements

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

Description of Violation

Resident #3 uses a CPAP at night, ordered on 3/21/223. However, resident #3's assessment, dated did not include the resident's need for a CPAP machine.

Plan of Correction ***Accept (- 09/26/2025)***

PCHA reviewed this resident's support plan and added CPAP usage and resident manages independently on 08/29/2025.

***09/26/2025- PCHA and LPN supervisor have audited all resident RASPS beginning on 09/01/2025. All RASPS were updated with any missing items during that audit. PCHA will begin quarterly auditing RASPS beginning 09/01/2025 to ensure compliance.*
PCHA and LPN supervisor are responsible for completion of RASPS. LPN supervisor was verbally educated on ensuring vital information is listed on 09/01/25

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented (- 09/30/2025)

227d - Support Plan Medical/Dental

10. Requirements

2600.

227d - Support Plan Medical/Dental *(continued)*

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

Description of Violation

Resident #2's assessment, dated [redacted] indicated the resident is able to self-administer medications without assistance per [redacted] DME; however, [redacted] must still successfully pass the SA assessment. Resident #2's support plan, dated [redacted] did not include the supports provided by the home as staff administer resident #2's medications.

Resident #3's assessment, dated [redacted], indicated the resident has a need for enabler for assistance with bed mobility. The resident's support plan, dated [redacted] did not reflect the intended use and any risks associated with the use of the assist bar, the resident's ability to use the device safely for the purpose it was intended, identification of the specific device to be used nor whether a cover is required to meet FDA guidelines.

Resident #4's assessment, dated [redacted] indicated that the resident has Obstructive Sleep Apnea. However, the support plan does not indicate that the resident utilizes a CPAP machine nor the staff support needed for the resident to use the machine.

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA reviewed resident 2 support plan. PCHA updated support plan on 09/01/2025 to indicate that while resident has ability to self store and self administer medications, [redacted] asks that staff manage some-not all. this is indicated on [redacted] self administer assessments.

PCHA reviewed resident 3 support plan on 08/29/2025- At time of inspections and on assessment dated [redacted] - the support plan DOES state need for enabler for bed mobility. It is noted in comments as well as under transfers. This was in compliance at time of survey on 08/28/2025. No changes were made at this time.

Resident 4 support plan was reviewed by PCHA on 08/29/2025 and PCHA added usage of CPAP and indicates that staff support is not needed for management as resident is able to self manage CPAP. This was corrected on 08/29/2025 and is now meeting compliance.

***09/26/2025- PCHA and LPN supervisor have audited all resident RASPS beginning on 09/01/2025. All RASPS were updated with any missing items during that audit. PCHA will begin quarterly auditing RASPS beginning 09/01/2025 to ensure compliance.*
PCHA and LPN supervisor are responsible for completion of RASPS. LPN supervisor was verbally educated on ensuring vital information is listed on 09/01/25.
See attached update to resident 3 RASP. ***(Directed) Resident #3's RASP was updated by 9/26/25-[redacted]***

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)

252 - Record Content

11. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
23. If the resident dies in the home, a copy of the official death certificate.

Description of Violation

Resident #5's record did not include a copy of the resident's official death certificate. The resident passed away in the home on [redacted]

Plan of Correction ***Accept ([redacted] - 09/26/2025)***

PCHA contacted funeral home on 09/01/2025 and requested copy of death certificate. Funeral home faxed over copy of signed death certificate and PCHA placed in residents closed record. PCHA will monitor resident records post death to ensure that certificates are completed and on file.

***09/26/2025- PCHA is responsible for obtaining and filing death certificates in resident records.*
No other residents have ceased to breath in last year.
PCHA will audit resident records at time of death beginning 09/01/2025 to ensure all necessary documents are on file and remain in compliance.

Licensee's Proposed Overall Completion Date: *09/26/2025*

Implemented ([redacted] - 09/30/2025)