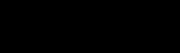
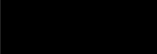


Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY PUBLIC

September 28, 2026

 ADMIN
WELSH MOUNTAIN HOME INC
567 SPRINGVILLE ROAD
NEW HOLLAND, PA, 17557

RE: WELSH MOUNTAIN HOME
567 SPRINGVILLE ROAD
NEW HOLLAND, PA, 17557
LICENSE/COC#: 32172

Dear 

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/19/2026, 08/20/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,



cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: WELSH MOUNTAIN HOME **License #:** 32172 **License Expiration:** 05/31/2027
Address: 567 SPRINGVILLE ROAD, NEW HOLLAND, PA 17557
County: LANCASTER **Region:** CENTRAL

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: WELSH MOUNTAIN HOME INC
Address: 567 SPRINGVILLE ROAD, NEW HOLLAND, PA, 17557
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: I-1 **Date:** 10/31/2024 **Issued By:** Township of Salisbury
Type: Other **Date:** 05/09/2023 **Issued By:** Township of Salisbury
Type: I-1 **Date:** 05/23/2025 **Issued By:** Township of Salisbury

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 42 **Waking Staff:** 32

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint, Incident **Exit Conference Date:** 08/20/2026

Inspection Dates and Department Representative

08/19/2026 - On-Site: [REDACTED]
08/20/2026 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 43 **Residents Served:** 42

Secured Dementia Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 22 **Are 60 Years of Age or Older:** 38
Diagnosed with Mental Illness: 2 **Diagnosed with Intellectual Disability:** 13
Have Mobility Need: 0 **Have Physical Disability:** 0

Inspections / Reviews

08/19/2026 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 09/07/2026

Inspections / Reviews (*continued*)

09/08/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2026

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 09/15/2026

09/08/2026 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2026

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 09/30/2026

09/28/2026 Document Submission

Submitted By: [REDACTED]

Date Submitted: 09/25/2026

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

On 12/14/2025, Resident #1 was yelling at other residents and holding [REDACTED] hand in a fist. After the area was cleared of residents, Resident #1 continued to yell at staff and hold [REDACTED] fist up to them. EMS was notified for a mental status change and the resident was transported to [REDACTED] Hospital to be evaluated. The home did not report this incident to the Department.

Plan of Correction

Accept ([REDACTED]) - 09/08/2026)

Resident 1 is no longer residing at Welsh Mountain Home and has been discharged [REDACTED]. The definitions of abuse and abuse reporting regulations will be reviewed at the September 8th staff meeting, please refer to the attached agenda. All reportable incidents and PEER events will be regularly reviewed and followed up on timely, we will then take results to the quarterly QI meeting. The Executive Director will be responsible for reviewing reportable and PEER reports and also bringing results to the QI meeting.

The ED submitted a reportable incident on 9/8/2026 (attached). For timely submissions of abuse reporting the Director of Wellness and the Executive Director will discuss all incidents reported by staff within 24 hours to determine if abuse reporting is warranted and submit a report to the department timely. In the event that the ED or DOW is not available, the Compliance officer or VP of Health Services at Landis Communities will be consulted. If the DOW or ED has any question regarding abuse reporting, they will consult the Compliance Officer or VP for guidance. PEER is an internal incident reporting software system that is reviewed by the Compliance Officer daily for Risk and Compliance issues. Reviewing the PEER incidents at QI will ensure that abuse reporting was done and provides accountability for reporting.

Licensee's Proposed Overall Completion Date: 09/08/2026

Implemented ([REDACTED]) - 09/28/2026)

85a - Sanitary Conditions**2. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On 8/20/2026 at 10:45 AM a 2" streak of feces was present on Resident #5's comforter and blood smears were present on the resident's pillowcase.

Plan of Correction

Accept ([REDACTED]) - 09/08/2026)

The resident's sheets and pillowcase were immediately changed, and all other beds were checked for soilage. Resident 5's linens will be checked daily for soilage. Residents will be asked to notify a team member if their linen is soiled at the Sept 4th resident council meeting. The regulation will be reviewed with team members at the September 8th staff meeting. PCAs will audit linens daily and the director of wellness will collect and review audits for compliance and bring to the quarterly QI meetings.

Licensee's Proposed Overall Completion Date: 09/15/2026

Implemented ([REDACTED]) - 09/28/2026)

85a - Sanitary Conditions (continued)

123c - Evacuation Diagrams

3. Requirements

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

The home currently serves 42 residents. The emergency evacuation diagrams posted in the home did not show the location of pull signals.

Plan of Correction

Accept () - 09/08/2026

Evacuation plans were updated by Cornerstone Design and posted on August 27th, and plans will be reviewed with team members at the Sept. 8th team meeting. See attached plans. The director of facilities will review plans monthly for compliance and will bring results to quarterly QI meeting.

Licensee's Proposed Overall Completion Date: 09/04/2026

Implemented () - 09/28/2026

183b - Meds and Syringes Locked

4. 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 8/20/2026, a tube of Family Care anti-itch and pain relief cream was unlocked, unattended, and accessible in resident room #208.

Plan of Correction

Accept () - 09/08/2026

The director of wellness immediately removed the medication from the resident's bathroom and placed it in the locked medication box for that resident. Weekly med-box audits will now check for medications found not to be stored in the lock box. Director of wellness will review weekly audits and bring results to quarterly QI meetings. Regulations regarding OTC medications, self-administered medications and medication safety were reviewed with residents during a resident council meeting on Sept 4th. Regulations will also be reviewed with team members at the Sept. 8th staff meeting.

Licensee's Proposed Overall Completion Date: 09/15/2026

Implemented () - 09/28/2026

184a - Resident's Meds Labeled

5. 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.

184a Resident's Meds Labeled (*continued*)**Description of Violation**

The sachet packets for Resident #5's Lamotrigine and Tamsulosin did not include instructions for administration.

The sachet packets for Resident #6's Glimepiride and Acetaminophen did not include instructions for administration.

The sachet packets for Resident #7's Olanzapine, Atorvastatin, Lorazepam, Quetiapine, Senna S, and Temazepam did not include instructions for administration.

Resident #8 was prescribed Ondansetron HCL 4mg take 1 tablet by mouth 3x a day 1 hour before meals. The pharmacy label for resident medication indicated take 1 tablet a day as directed.

Plan of Correction

Accept () - 09/08/2026

The pharmacy was contacted and sachet packs will contain all prescribed dosage and instructions on the pack starting September 11th. Regulations will also be reviewed with team members at the Sept. 8th staff meeting. Weekly medication packaging audits will be done by the director of wellness or designee for compliance. Results will be taken to the quarterly QI meetings.

Licensee's Proposed Overall Completion Date: 09/11/2026

Implemented () - 09/28/2026

187d - Follow Prescriber's Orders

6. Requirements

2600.

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

Description of Violation

Resident #9 was prescribed Easy Touch Safety 30g Lancets use 4 times a day to test blood sugar notify CRNP if BS < 100 / > 400. On 8/2/2026 at 7:00 AM, the resident had a blood sugar reading of 96. On 8/7/2026 at 12:00PM, the resident had a blood sugar reading of 93. The CRNP was not notified of these readings.

Plan of Correction

Accept () - 09/08/2026

The CRNP was immediately notified of the low glucose reading for resident 9. An email was immediately sent to the PCA department reviewing the importance of following protocol and providers orders regarding notifications and parameters. Please find the signed emails. The regulation will be reviewed at the September 8th staff meeting. Weekly glucometer audits will now check that all readings outside of parameters were sent to provider for review. The director of wellness will bring audits to the quarterly QI meetings.

Licensee's Proposed Overall Completion Date: 09/15/2026

Implemented () - 09/28/2026

190a - Completion Medication Course

7. 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.

190a - Completion Medication Course (continued)**Description of Violation**

Staff Member B, who had not successfully completed the Department-approved medications administration course as evidenced by an initial medication administration total training score of 88.5%.

Resident #2 – Levothyroxine on 8/5/2026, 8/8/2026, 8/9/2026 at 5:30AM

Resident #5 – Tamsulosin on 8/1/2026, 8/7/2026, 8/8/2026 at 9:00PM

Staff Member D, who had not successfully completed the Department-approved medications administration course as evidenced by an incomplete initial medication administration training user report and incomplete annual practicum requalification due 1/2026, administered medications to the following residents:

Resident #6 - Acetaminophen ER on 8/3/2026, 8/11/2026, 8/17/2026 at 8:00PM

Resident #9 - Atorvastatin on 8/3/2026, 8/11/2026, 8/17/2026 at 8:00PM

Staff Member E, who had not successfully completed the Department-approved medications administration course as evidenced by an incomplete initial medication administration training user report and incomplete annual practicum requalification, administered medications to the following residents:

Resident #6 - Align 4MG on 8/2/2026 at 7:00AM

Resident #6 - Fenofibrate 160MG on 8/2/2026 at 7:00AM

Staff Member F, who had not successfully completed the Department-approved medications administration course as evidenced by an incomplete initial medication administration training user report and incomplete annual practicum requalification's, administered medications to the following residents:

Resident #2 - Levothyroxine on 8/3/2026, 8/4/2026, 8/10/2026, 8/11/2026 at 5:30AM

Resident #6 – Acetaminophen on 8/2/2026 at 8:00PM

Staff Member G, who had not successfully completed the Department-approved medications administration course as evidenced by an incomplete initial medication administration training user report, administered medications to the following residents:

Resident #2 – Eliquis on 8/3/2026 at 7:00AM, 8/16/2026 at 8:00PM

Resident #5 – Tamsulosin on 8/2/2026, 8/4/2026, 8/18/2026 at 9:00PM

Plan of Correction**Accept () - 09/08/2026**

Staff member B has been removed from the med cart immediately following discovery of non-passing grade and will retake the medication administration course. Staff members D, E, F, G have been removed from the med cart upon receipt of this violation report and will update their user report for compliance or retake course. All other med tech user reports will be audited for compliance by 9/30/26. Training completed with practicum observer on how to accurately record MAR reviews and medication observations on Aug. 21st. The med tech trainer will audit observations for accuracy of recording. The requirements for successfully completing the medication technician training were reviewed by the med-tech trainer. On August 25th the trainer reviewed the ODP training manual and confirmed that passing the course requires all of the following: A score of 90 or higher on the written exam, proper documentation of the trainer and student attestation, and all four medication observations must be recorded with a date before the User Report is printed. Human Resources was trained on regulations for compliance of med tech training requirements for newly hired team member onboarding with previously completed med tech training from a different agency. Med tech trainer will review all new hire med tech training documents to assure compliance before team member may pass meds.

Licensee's Proposed Overall Completion Date: 09/30/2026

190a Completion Medication Course (*continued*)

Implemented () - 09/28/2026

190c Record of Training

8. Requirements

2600.

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

Description of Violation

The home's medication administration training record for Staff Member C does not include completed summary and certification annual practicum documentation for training years 2024 and 2025.

Plan of Correction

Accept () - 09/08/2026

Staff member C has been removed from the med cart upon receipt of this violation report and will update their annual practicum observations. All other med tech annual practicums will be audited for compliance by 9/30/26. Training completed with practicum observer on how to accurately record MAR reviews and medication observations on Aug. 21st. The med tech trainer will audit observations for accuracy of recording. Audit results will be taken to quarterly QI meetings.

Licensee's Proposed Overall Completion Date: 09/30/2026

Implemented () - 09/28/2026

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 #1's assessment, dated [REDACTED], indicated that the resident had no problem with orientation to time, person, place, irritability, judgment, agitation, and aggression. On [REDACTED], Resident #1 was found walking in the middle of the road with active traffic moving around the resident. Resident #1 was making statements that [REDACTED] didn't have a heart and that it was taken out on that date. Resident #1 refused to return to the home and was transported via EMS to the hospital. Hourly checks were implemented following this incident. On [REDACTED] Resident #1 was yelling at and holding a fist to other residents and staff and was transported by EMS to the hospital due to a mental status change. Resident #1's assessment was never updated to reflect the resident's change in needs.

Resident #5's assessment, dated [REDACTED], indicated that the resident had several cavities causing issues with swallowing and pain and that the POA is working on finding a dentist to remove teeth. The assessment indicated that the resident had a need for personal hygiene assistance and staff brush [REDACTED] teeth. On [REDACTED] Resident #5's teeth were removed. The resident's assessment was not updated to reflect a change in need.

Plan of Correction

Accept () - 09/08/2026

Resident #1 has been discharged [REDACTED]. Resident #5's RASP was updated to reflect the removal of teeth and updated dental need for assistance with oral hygiene. Director of wellness will evaluate changes in

225c - Additional Assessment (continued)

condition to ensure compliance with completed assessments and bring results to quarterly QI meetings. RASP training will be done with all staff at the September 8th staff meeting.

The ED and Director of Wellness will complete an audit on all residents for assessment accuracy by 9/15/2026. Starting October 5th, the Director of Wellness and ED will meet, monthly, to review all resident condition changes and/or procedures and new orders, and update the RASP as needed.

Licensee's Proposed Overall Completion Date: 09/15/2026

Implemented () - 09/28/2026)

227d - Support Plan Medical/Dental**10. Requirements**

2600.

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

Description of Violation

The assessment and support plan for Resident #2, dated [REDACTED] did not reflect the resident's alternate sleeping arrangement as the resident preferred to use a recliner.

Plan of Correction

Accept () - 09/08/2026)

Resident #2's RASP was immediately updated to reflect [REDACTED] preference to sleep in a recliner. Staff will be educated on RASP development at the September 8th staff meeting. The executive director will audit Support Plans monthly to ensure compliance with completed assessments and bring results to quarterly QI meetings.

Licensee's Proposed Overall Completion Date: 09/15/2026

Implemented () - 09/28/2026)