Department of Human Services
Bureau of Human Service Licensing

January 20, 2022

[redacted]
COLUMBIA WEGMAN SOUTHAMPTON LLC
[redacted]

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

Dear [redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/16/2021, 08/03/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Claire Mendez

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *THE LANDING OF SOUTHAMPTON* **License #:** *14538* **License Expiration:** *02/10/2022*

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

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

Administrator

Name: [redacted] **Phone:** *2157916666* **Email:** [redacted]

Legal Entity

Name: *COLUMBIA WEGMAN SOUTHAMPTON LLC*

Address: [redacted]

Phone: *2157916666* **Email:** [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date:** *09/20/2019* **Issued By:** *Upper Southampton*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *50* **Waking Staff:** *38*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date:** *08/03/2021*

Inspection Dates and Department Representative

07/16/2021 - On-Site: [redacted]

08/03/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served:** *39*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Opal* **Capacity:** *36* **Residents Served:** *11*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *38*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *11*

Have Physical Disability: *2*

Inspections / Reviews

07/16/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/14/2021*

Inspection Dates and Department Representative *(continued)*

10/14/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/19/2021*

10/26/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/05/2021*

01/20/2022 - Document Submission

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 [redacted]/21, Resident #1 had an unwitnessed fall and sustained deep skin tears on the right hand and right elbow. The resident was transported to the hospital and discharged the following day. The home did not submit an incident report to the Department.

Plan of Correction ***Accept***

The community's electronic incident reporting system has been set to send electronic notifications to the General Manager (GM) and Health and Wellness Director (HWD). The GM or designee is responsible for reviewing incident reports within 24 hours to determine whether further investigation and/or action is required, including whether the incident is reportable in accordance with Appendix A of the Personal Care Home Interpretive Guide. GM was reeducated on the importance of timely follow up of incident reports by Ops Director. Since GM is no longer employed, this will be included as part of orientation going forward.

Document Submission ***Implemented***

Interim Administrator will oversee compliance with this requirement.

17 - Record Confidentiality

1. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 7/16/21, at 2:03 pm, resident records were unlocked, unattended, and accessible in the secure dementia unit medication room.

Plan of Correction ***Accept***

The door to the medication room is outfitted with an automatic door closer hinge and latching/locking hardware but staff had propped the door open. The GM has reviewed confidentiality and safety standards with the staff member who was responsible for the medication room at the time of the observed violation. In-service/refresher training for all staff regarding confidentiality and safety has been conducted for all staff, including clarification that doors are not to be propped open. As part of the community's ongoing safety observation/quality assurance plan, all staff are responsible for resolving and/or reporting violations of the community confidentiality policy and/or safety practices.

Document Submission ***Implemented***

All staff have been trained on record confidentiality, see attached documentation of training.

42b - Abuse

1. 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.

42b - Abuse *(continued)*

Description of Violation

On [redacted] 21 at [redacted] am, resident #2 was observed in the resident's bed wearing only an adult brief and a short sleeved T-shirt. The room felt extremely cold, and the thermostat read 69 degrees Fahrenheit. The air-conditioning unit was continually blowing cold air. The resident's blanket was hanging off of the bottom of the bed and the resident's legs were uncovered. Resident #2 was laying on [redacted] back with legs crossed, arms curled close to the trunk of the body, and hands tucked under the chin. Resident #2 requires assistance with transferring in/out of bed/chair and is receiving hospice services. Resident #2 also stated that the resident was not yet fed breakfast. Per staff member A's statement there are 11 residents to wake up, change, dress, and transport to the dining room for breakfast and the staff person was not able to attend to resident #2.

Plan of Correction ***Accept***

Resident #2 had been assessed being independent getting out of bed and only needing reminders to attend meals. Resident was assessed and scheduled to receive assistance with dressing and grooming at 8 am. The HWD will utilize the community's electronic assessment and support planning tool to ensure approximate service times are mutually agreed upon based on resident needs and preferences and that adequate staff are scheduled to meet resident needs. The HWD will assess whether a resident is able to effectively manage the thermostat controls in [redacted] apartment and if resident is unable to manage control, community staff will assist resident in setting thermostat to a comfortable temperature per resident preference. Community will ensure thermostats will not be set below 70 degrees, unless resident prefers otherwise.

The HWD will re-orient the Resident Assistants to ensure that they properly document "rescheduled services" or missed services in the electronic record if a resident declines the timing of a scheduled service, if there are circumstances that prevent the scheduled service from being completed at the approximate time, or if the service is not provided. The HWD or designee will review the electronic record dashboards daily to address variances from the support plan. The GM will review dashboards on a weekly basis as part of the community's quality management program. Representatives from the corporate office will conduct periodic clinical and operational audits to monitor the community's application of policies and procedures.

Document Submission ***Implemented***

All staff have been trained on service plan delivery for unscheduled services, as well as the regulation stated above, see attached documentation of training.

51 - Criminal Background Check

1. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff member A, hired on [redacted] /21, did not have a criminal background in file.
Staff member B, hired on [redacted] /21, did not have a criminal background in file.

Plan of Correction ***Accept***

The community did conduct background checks and have them on file for both Staff member A and B, however the

51 - Criminal Background Check (continued)

checks did not comply with all the elements identified in §2600.51. The GM and Business Office Manager will utilize the background check system prescribed by the Section for staff A, & B, or any affected existing staff and new employees. The GM is responsible for conducting a review of new employee records to ensure they meet the community's conditional offer of employment and is responsible for removing staff who do have not met the requirements from the work schedule until resolved or will enact a separation.

Document Submission ***Implemented***

Interim Administrator has confirmed a background check has been completed and is on file for all staff.

60b - Additional Staffing

1. Requirements

2600.
60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

On 7/16/21 at 2:30 pm, while interviewing staff member B, resident #1, who resides in the SDCU was asking for assistance with transferring out of bed to go to the common area. Resident #1's RASP indicates that the resident requires the assistance of one direct care staff person to transfer in/out of bed/chair. Only one staff was assigned to perform direct care duties for the SDCU and was busy assisting another resident and not able to attend to resident #1's needs.

Per staff member A, during morning hours in the SDCU, the staff member is responsible for performing ADLs for all 11 residents in the unit, and must assist residents with transferring, toileting, changing, and transporting residents to the common area for breakfast. The staff member stated that one other staff person administers medications during this time and is not available to assist with direct care.

Plan of Correction ***Do Not Accept***

The HWD will utilize the community's electronic assessment, support planning and task assignment tool to ensure that adequate staff are scheduled to meet resident needs. The HWD will re-orient the Resident Assistants to ensure that they properly document "rescheduled services" or missed services in the electronic record if a resident declines the timing of a scheduled service, if there are circumstances that prevent the scheduled service from being completed at the approximate time, or if the service is not provided. Unscheduled services such as transfer assistance are supported by non-direct care staff on duty. The HWD and GM will ensure direct care staff and non-direct care staff are trained to provide transfer assistance and/or aware that non-direct care staff may be summoned to assist should a direct care staff member not be available.

The HWD or designee will review the electronic record dashboards daily to address variances from the support plan. The GM will review dashboards on a monthly basis as part of the community's quality management program. Representatives from the corporate office will conduct periodic clinical and operational audits to monitor the community's application of policies and procedures.

60b - Additional Staffing (continued)

Plan of Correction ***Accept***

The community will only use staff who meet the minimum education requirements and complete the Department-approved training course/pass the competency test to assist with ADLs, including transfer assistance. These individuals may be assigned the title Resident Assistant (typically considered direct care staff), or other job titles such as Opal Program Assistant, Opal Program Assistant, Opal Program Manager, Opal Manager and General Manager, who are properly credentialed but are not necessarily categorized as direct care staff by the community.

As of the date of this revised plan of correction, the individuals working in the HWD and GM roles are no longer employed at the community. Representatives of and staff from the corporate office will oversee the implementation of this plan of correction and will complete re-assessment of affected residents by 11/1/21.

Document Submission ***Implemented***

Interim Administrator and Business Office Manager will review credentials of all direct care staff going forward to make certain they have completed the Department approved training course and successfully passed the competency test.

65d - Initial Direct Care Training

1. 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

Direct care staff person B, hired on [redacted]/21, began providing unsupervised ADL services on [redacted]21. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction ***Accept***

Direct care staff person B is licensed as a nurse in the State of [redacted]. Although Pennsylvania has passed the Nursing Licensure Compact exempting licensed nurses from the Department-approved training and competency test, [redacted] is not a participating state. The affected staff member will complete the required course/test and a note regarding the discrepancy of the training/test date and provision of unsupervised ADL services will be noted in the employee record.
The corporate office staff provided the GM with a link to the multi-state nursing compact site to verify whether a licensed nurse is exempt from this requirement. The GM, in conjunction with the HWD, will ensure proper supervision is provided as specified in this section.

Document Submission ***Implemented***

Interim Administrator and Business Office Manager will review credentials of all direct care staff going forward to make certain they have completed the Department approved training course and successfully passed the competency test. Staff person B is currently [redacted] from the community and will not be returning to work after [redacted] is over.

185a - Implement Storage Procedures

1. 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

Resident #1 is prescribed Senna Plus .50mg Tab as needed. On 08/03/21 this medication was not available in the home.

Plan of Correction ***Accept***

Corporate office staff have reviewed the provisions of the community's Medication Services Policy with the GM and HWD. It is the responsibility of the HWD to ensure medications are obtained in a timely manner for residents on medication services. If the medication is not available, it is a medication error requiring the completion of a medication incident report and verbal report to the HWD or GM if the HWD is not available for consultation.
The GM and HWD completed in-service training with staff assigned to provide medication services to clarify that the non-availability of a medication is a medication error and they must follow the community's medication error reporting and documentation standards. In addition to receiving verbal reports of errors, the community's electronic incident reporting platform will notify the GM and HWD that a medication error has occurred, and it must be reviewed/investigated within 24 hours and ensure appropriate action it taken to resolve the situation. In addition to the ongoing monitoring of incidents, the corporate office will periodically monitor the community's compliance through operational and clinical audits.

Document Submission ***Implemented***

All staff responsible for medication assistance have been trained on medication practices and what constitutes a medication error, see attached documentation of training.

231c - Preadmission Screening

1. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident # 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. However, the resident # 1's written cognitive preadmission screening was not completed.

Resident # 3 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/20. However, the resident # 3's written cognitive preadmission screening was completed on [redacted]/20.

Plan of Correction ***Accept***

The HWD shall utilize the community's electronic assessment platform to schedule preadmission screenings for each prospective SDCU resident. Should the resident's anticipated admission date change, the HWD is responsible for rescheduling the screening to comply with the required timeframe. The GM is responsible for monitoring admission timelines, licensing requirements and the overall operation of the community.

Document Submission ***Implemented***

Interim Administrator will ensure ongoing compliance.

231e - No Objection Statement

1. Requirements

2600.
231.e. Each resident record must have documentation that the resident and the resident's designated person have not objected to the resident's admission or transfer to the secured dementia care unit.

Description of Violation

Resident # 1 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Resident # 2 was admitted to the Secure Dementia Care Unit (SDCU) on [redacted]/21. The home has no documentation that the resident and the resident's designated person have not objected to the admission.

Plan of Correction ***Do Not Accept***

In accordance with the community's Resident Agreement policy that was accepted by licensing, a properly executed Resident Agreement and other signed documents that are part of the move-in process shall serve as written consent for admission the community's designated SDCU. The Agreement includes the following statements that indicate there are no objections to the admission:
• Owner desires to rent an Apartment in the Community to Resident, and Resident desires to take and rent such Apartment from Owner.
• Owner rents and leases to Resident, and Resident takes and leases from Owner, the Apartment upon all the following terms and conditions.
• The designated Opal program area utilizes a delayed egress system for entrances/exits.
• My signature below, as Resident or authorized representative of Resident, indicates that I have read or had read and explained to me, the provisions of this Agreement, I have had the opportunity to consult with an attorney of my choosing prior to executing this Agreement and I fully understand and enter into this Agreement and the attached addenda voluntarily.
A signed Resident Agreement was present in Resident #1's financial file at the time of the inspection.

Plan of Correction ***Accept***

Although not all residents are admitted to the SDCU when moving into the community, the community's Resident Agreement Policy requires that a new Agreement be executed for all in-house moves, so the language quoted is specific to the admission to the SDCU prior to the resident's transfer to the new apartment.

From Resident Agreement Policy:
A new Resident Agreement must be executed any time a resident moves to a different apartment within the community.

231e - No Objection Statement (continued)

The Resident Agreement has been modified as written below:
My signature below, as Resident or authorized representative of Resident, indicates that I have read or had read and explained to me, the provisions of this Agreement, I have had the opportunity to consult with an attorney of my choosing prior to executing this Agreement and I fully understand and enter into this Agreement and the attached addenda voluntarily and do not object to placement in a secured dementia care unit.

Document Submission ***Implemented***

See attached Resident Agreement for new language described.
Both resident #1 and #2 have passed away and are no longer residents of the community.

234d - Support Plan Revision

1. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

A support plan for resident #1 was completed on [redacted]/21. Resident #1 has fallen several times since the support plan completion - [redacted]/21 [redacted]/21, [redacted]/21, [redacted]/21, [redacted]/21, [redacted]21, [redacted]/21, [redacted]/21, and [redacted]21 - several of which resulted in injury requiring care and treatment from a hospital. The resident's support plan has not been revised to address the resident's frequent falls.

Plan of Correction ***Do Not Accept***

Corporate office staff have reviewed the community's assessment and service/support planning practices with the GM and HWD to ensure both are aware of their role in reviewing incidents within 24 hours and conducting re-assessments, including using the community's Balance Builders fall assessment tools, to address significant changes in a resident's condition. Based on the change of condition assessment, both temporary and ongoing support plans will be developed to identify interventions such as care coordination with home health and hospice providers, measures/monitoring to prevent illnesses such as urinary tract infections, medication reviews and disease progression considerations. Proper use of the community's electronic platform will provide a monitoring system to ensure ongoing quality management processes are in place.

Plan of Correction ***Accept***

Resident #1's support plan has not been updated. Resident #1 was a hospice patient whose death was pronounced by the hospice provider on [redacted]2021.

Document Submission ***Implemented***

Interim Administrator will monitor for continued compliance.