Department of Human Services
Bureau of Human Service Licensing

April 11, 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 02/07/2022, 02/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Shawn Parker

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**: *02/10/2023*

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

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

Administrator

Name: [redacted] **Phone**: *215-791-6666* **Email**: [redacted]

Legal Entity

Name: *COLUMBIA WEGMAN SOUTHAMPTON LLC*

Address: [redacted]

Phone: *215-791-6666* **Email**: [redacted]

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *48* **Waking Staff**: *36*

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *02/08/2022*

Inspection Dates and Department Representative

02/07/2022 - On-Site: Christina Eberhart

02/08/2022 - On-Site: Christina Eberhart

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *106* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Opal* **Capacity**: *31* **Residents Served**: *9*

Hospice

Current Residents: *1*

Number of Residents Who:

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

Diagnosed with Mental Illness: *18* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *10* **Have Physical Disability**: *1*

Inspections / Reviews

02/07/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2022*

Inspections / Reviews *(continued)*

04/01/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/08/2022*

04/11/2022 - Document Submission

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

According for PA Health Alert Network 597 (PA HAN 492) dated 4/3/20 and Center for Disease Control (CDC) guidance, universal masking for staff in long term care facilities should be implemented in Long Term Care Facilities to minimize the risk of transmission of COVID-19.

On 2/7/22 at 12:04 pm, Staff Member A was sitting in the main lobby with a guest and not wearing a mask.

On 2/7/22 at 12:12 pm, Staff Member A was at the receptionist's desk not properly masked. The staff member's nose was not covered.

On 2/7/22 at 1:15 pm, Staff Member B was sitting at a table in Opal with two residents doing a coloring activity. The residents were not wearing masks. The staff member was not properly masked. The staff member's nose was not covered.

On 2/8/22 at 9:40 am, Staff Member C entered Resident #1's room to perform care. The staff member was not masked.

On 2/8/22 at 9:40 am, Staff Member D entered Resident #1's room to perform care. The staff member was not properly masked. The staff member's nose was not covered.

Plan of Correction ***Accept***

In accordance with PA HAN current Guidelines, all staff members must be masked (nose and mouth fully covered) when engaging with residents. All staff have been advised on the current guidance for wearing masks when in common areas and/or when in close proximity to residents, and following amendments to applicable laws as they are established and reviewed with community staff. Further violations will result in write ups and disciplinary actions. GM, HWD and all Managers will daily, monitor staff and address instances of non-compliance with current guidance to minimize the risk of transmission of COVID-19.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Ongoing monitoring and enforcement

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident’s designated person if any, prior to signature.

Description of Violation

Resident #3, admitted [redacted]/20, did not have a resident-home contract completed until [redacted]/20.

Plan of Correction ***Accept***

Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its

25a - Written Contract and Review (continued)

contents to the resident and the resident's designated person if any, prior to signature.

The Administrator/GM who was deficient in signing the contract for this violation is no longer employed with the community. The deficient practice cannot be corrected for this resident. A note will be placed in this resident's record and will be placed in the records of other residents who were affected by this deficient practice.

All contracts for new resident move-ins are signed by the GM prior to admission. A Move In Checklist identifying paperwork and timelines had been created for use at the community to ensure the contract is properly executed prior to admission.
The Operations Leader conducts periodic Operations Audits which include a review of the Move In Checklist.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

A note will be placed in affected resident's files indicating this was an error on the part of prior administrator and has been recorded as such by DHS via this inspection.

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.

Description of Violation

Resident #2 and Resident #4, who share a room, were told by staff to stop pushing call bells because no one would be coming to help them.

Resident #4 is listed as a moderate fall risk on the resident's support plan dated [redacted]/21. On [redacted]/21 the resident fell in the resident's bathroom and pressed the pendant for help. The resident estimates it took 30 minutes for someone to come check on the resident. The resident suffered a hip injury as a result of the fall.

Resident #5 reports being left on the toilet anywhere from 30 minutes to over an hour. Per the resident's support plan dated [redacted]/21, the resident relies on staff for toileting. The call bell report shows multiple occasions where staff took anywhere from 15 minutes to over 3 hours to respond to the resident's call bells.

Resident #6 reports being left on the toilet usually up to one hour. Per the resident's support plan dated [redacted]/21, the resident relies on staff for toileting. The call bell report shows multiple occasions where staff took anywhere from 15 minutes to over 3 hours to respond to the resident's call bells. Resident 6 reports falling in the bathroom trying to use the toilet because staff took to long to respond.

Plan of Correction ***Accept***

The General Manager (GM) conducted training for all staff regarding residents' rights to be free from abuse including, but not limited to, speaking to residents in a disrespectful manner or in a manner that could be perceived as disrespectful or intimidating, neglecting a resident's scheduled or unscheduled care needs, and/or mistreating or disciplining a resident in any way. Staff who are aware of abuse or suspected abuse are mandated reporters and are subject to disciplinary action, up to and including separation of employment, and criminal charges in accordance with applicable law. Staff who have been determined to be in violation of a resident's rights, including abuse, are

42b - Abuse (continued)

subject to disciplinary action, up to and including separation of employment, and criminal charges in accordance with applicable law.

Care staff, front desk receptionists and Department Supervisors were re-oriented regarding each person's roll in ensuring call bells are responded to in a timely manner and for communicating between each other and the Manager on Duty should an alarm not be re-set in a timely manner.

The General Manger provided additional training for care staff and supervisors regarding how the community's electronic assessment, service planning and incident reporting platform is to be used to document a resident's non-emergent use of the call bell to identify service planning needs and resident service preferences. Individual residents who have had a pattern of using the call system for non-emergent needs were re-oriented to the use of the community's call bell purpose and processes for contacting staff for non-urgent needs. Resident service plans are being updated and will more clearly provide instruction to staff regarding each resident's needs, abilities, and preferences.

At the time of Resident #4's fall on [redacted]/21, it was determined that a technical issue was impacting the proper operation of the call bell system. Staff have been re-oriented to the community's call bell malfunction practices identified in the Emergency Procedures Manual, which includes documenting walks through the community using the Fire Watch Log and implementing temporary e-call device alternatives until the functionality of the system is restored.

The GM, Health & Wellness Director (HWD) and/or Manager on Duty will review the call bell response times on a regular basis to identify alarms that were not reset in a timely manner and will investigate/take appropriate actions as necessary. The GM and HWD receive automated notices regarding incidents and are responsible for reviewing electronic dashboards to identify, investigate and resolve potential issues.
Representatives from the corporate office conduct periodic clinical and operational audits to help ensure the community's quality assurance programs are in place.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Conducted Staff Meeting to address response times to all call bells - to ensure safety and well-being of residents; redirected residents to use call bells for emergency use only and provided alternative means of contacting care staff for all other issues. Directed staff to document excessive use of call bells or non-emergency use via software tool.

DOW and staff reviewed/revised care plans accordingly so staff are clear on all resident needs, abilities and preferences. Reiterated process in the event of a system issue - to conduct and log building walkthroughs.

GM and DOW regularly reviewing call bell response times and incident reports to address timeliness of response.

42c - Treatment of Residents

1. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

42c - Treatment of Residents *(continued)*

Description of Violation

Resident #5 reports being left on the toilet anywhere from 30 minutes to over an hour. Per the resident's support plan dated [redacted]/21, the resident relies on staff for toileting. The call bell report shows multiple occasions where staff took anywhere from 15 minutes to over 3 hours to respond to the resident's call bells.

Resident #6 reports being left on the toilet usually up to one hour. Per the resident's support plan dated [redacted]/21, the resident relies on staff for toileting. The call bell report shows multiple occasions where staff took anywhere from 15 minutes to over 3 hours to respond to the resident's call bells. Resident #6 reports falling in the bathroom trying to use the toilet because staff took to long to respond.

Plan of Correction ***Accept***

The General Manager (GM) conducted training for all staff regarding residents' rights to be free from abuse including, but not limited to, speaking to residents in a disrespectful manner or in a manner that could be perceived as disrespectful or intimidating, neglecting a resident's scheduled or unscheduled care needs, and/or mistreating or disciplining a resident in any way. Staff who are aware of abuse or suspected abuse are mandated reporters and are subject to disciplinary action, up to and including separation of employment, and criminal charges in accordance with applicable law. Staff who have been determined to be in violation of a resident's rights, including abuse, are subject to disciplinary action, up to and including separation of employment, and criminal charges in accordance with applicable law.

Care staff, front desk receptionists and Department Supervisors were re-oriented regarding each person's roll in ensuring call bells are responded to in a timely manner and for communicating between each other and the Manager on Duty should an alarm not be re-set in a timely manner.

The General Manger provided additional training for care staff and supervisors regarding how the community's electronic assessment, service planning and incident reporting platform is to be used to document a resident's non-emergent use of the call bell to identify service planning needs and resident service preferences. Individual residents who have had a pattern of using the call system for non-emergent needs were re-oriented to the use of the community's call bell purpose and processes for contacting staff for non-urgent needs. Resident service plans are being updated and will more clearly provide instruction to staff regarding each resident's needs, abilities, and preferences.

At the time of Resident #4's fall on [redacted]/21, it was determined that a technical issue was impacting the proper operation of the call bell system. Staff have been re-oriented to the community's call bell malfunction practices identified in the Emergency Procedures Manual, which includes documenting walks through the community using the Fire Watch Log and implementing temporary e-call device alternatives until the functionality of the system is restored.
The GM, Health & Wellness Director (HWD) and/or Manager on Duty will review the call bell response times on a regular basis to identify alarms that were not reset in a timely manner and will investigate/take appropriate actions as necessary. The GM and HWD receive automated notices regarding incidents and are responsible for reviewing electronic dashboards to identify, investigate and resolve potential issues.
Representatives from the corporate office conduct periodic clinical and operational audits to help ensure the community's quality assurance programs are in place.

Completion Date: *03/24/2022*

42c - Treatment of Residents *(continued)*

Document Submission ***Implemented***

Conducted Staff Meeting to address response times to all call bells - to ensure safety and well-being of residents; redirected residents to use call bells for emergency use only and provided alternative means of contacting care staff for all other issues. Directed staff to document excessive use of call bells or non-emergency use via software tool. DOW and staff reviewed/revised care plans accordingly so staff are clear on all resident needs, abilities and preferences. Reiterated process in the event of a system issue - to conduct and log building walkthroughs.
GM and DOW regularly reviewing call bell response times and incident reports to address timeliness of response.

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/7/21 at 1:20 pm, there was a damaged ceiling tile in the hallway in OPAL. The tile appeared to be water damaged.

Plan of Correction ***Accept***

The General Manager reviewed the community's expectation that the community shall be maintained to ensure the environment is safe and sanitary for residents, staff, and visitors with all staff. Community staff are to complete both formal and informal building rounds and observations. All staff are responsible for taking corrective action within the scope of their training or reporting conditions they are unable to resolve including, but not limited to, damaged flooring, water leaks/evidence of leaks and inoperable/problematic systems. If a problematic condition cannot be resolved upon investigation of the cause, community staff will complete a work order in the community's electronic work order platform. The General Manager and Plant Operations Supervisor are responsible for monitoring the platform reports to ensure the maintenance issue is tracked for prompt resolution.

The physical plant items that were identified in the Department's findings for this citation have been corrected.

Completion Date: *03/31/2022*

Document Submission ***Implemented***

Ceiling tile was repaired

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The shower in Resident #2's bathroom has a broken floor partition. This causes water to leak onto the floor and become slippery posing a tripping hazard.

The shower in Resident #4's bathroom does not allow water to drain properly, and it overflows onto the bathroom floor. This causes water to leak onto the floor and become slippery posing a tripping hazard.

The door in memory care does not close all the way, leaving the call bell activated for that area. According to staff, the call bell stays activated if the door is still ajar.

95 - Furniture and Equipment *(continued)*

Plan of Correction ***Accept***

The GM reviewed the community's expectation that the community shall be maintained to ensure the environment is safe and sanitary for residents, staff, and visitors with all staff. Community staff are to complete both formal and informal building rounds and observations. All staff are responsible for taking corrective action within the scope of their training or reporting conditions they are unable to resolve including, but not limited to, damaged flooring, water leaks/evidence of leaks and inoperable/problematic systems. If a problematic condition cannot be resolved upon investigation of the cause, community staff will complete a work order in the community's electronic work order platform. The General Manager and Plant Operations Supervisor are responsible for monitoring the platform reports to ensure the maintenance issue is tracked for prompt resolution.

The physical plant items that were identified in the Department's findings for this citation have been corrected.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Resident #2 shower partition corrected; Resident #4 shower partition corrected; drain snaked to allow water to drain properly to avoid overflow.

Memory doors confirmed closing properly - identified issue via door alarm provider with sensor that causes alarm to erroneously alert - adjusted magnet to avoid false alarms. Plant Ops monitoring door alerts on regular basis.

141a 1-10 Medical Evaluation Information

1. Requirements

2600.
141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's medical evaluations dated [redacted]/20 and [redacted]/22 do not include medication and medication regimen.

Plan of Correction ***Accept***

The medication and medication regimen for Resident #1 was an attachment which inadvertently separated from the initial evaluation. This has been rectified and both the medication and medication regimen paperwork are attached to the DME. HWD will conduct regular chart audits to ensure DMEs and related paperwork are in place.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Medication and Medication Regimen paperwork are attached to the DME

227d - Support Plan Medical/Dental

1. 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 for resident #1, dated [redacted]/21, indicates the resident has a need for assistance with transferring in and out of bed. The resident's support plan, dated [redacted]/21 does not document the bedrails the resident uses to transfer

The assessment for Resident #4 dated [redacted]/21 indicates the resident is a high fall risk. The support plan mentions pendant as a part of the home's solution to meet the resident's need. According to call bell reports, staff are not responding when the resident presses the pendant.

The assessment for Resident #5 dated [redacted]/21 indicates the resident is a high fall risk. The support plan mentions pendant as a part of the home's solution to meet the resident's need. According to call bell reports, staff are not responding when the resident presses the pendant.

The assessment for Resident #6 dated [redacted]/21 indicates the resident is unable to ambulate. The support plan mentions pendant as a part of the home's solution to meet the resident's need. According to call bell reports, staff are not responding when the resident presses the pendant.

Plan of Correction ***Accept***

The community's Corporate Health Services team has conducted training with the community's GM, HWD and Opal (Memory Care) Manager to ensure they are familiar with the company's electronic assessment and service planning platform's "wizard" tool that aligns needs and preferences identified in the assessment with the service plan and staff task schedules.

Resident assessments and support plans are being reviewed to ensure the assessment and service plans for all residents correlate as they should.

The GM, HWD and Opal Manager will review the wizard tool with the community's other qualified assessors and will monitor reports that confirm the correct application of the wizard tool.

Completion Date: *03/31/2022*

Document Submission ***Implemented***

Ongoing monitoring and review

227i - Support Plan Accessible

1. Requirements

2600.
227.i. The support plan shall be accessible by direct care staff persons at all times.

Description of Violation

According to staff interviews, resident support plans are inaccessible to direct care staff.

227i - Support Plan Accessible *(continued)*

Plan of Correction ***Accept***

All support plans are available to all direct staff at all times through the community's electronic assessment, service planning and documentation platform. Direct care staff were re-oriented to the proper use of the platform and how the company's reference to "Eldermark" correlates to the personal care home reference to "support plans".

A Health and Wellness Training Supplement has been developed as a component of the New Employee Orientation program and includes information about service agreements, the community's "Eldermark" platform and variances in PCH references/terminology. Agency staff orientation tools have also been developed for use at the community.

The HWD will make certain that all staff are aware of the location of the support plans and will document training for staff and agency staff using the onboarding checklists developed for use at the community. The General Manager will review onboarding checklists thirty days after date of hire to ensure conditions of employment, including training, have been completed.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Revisited with all staff to ensure they are aware of location of support plans via training and onboarding checklists

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 #7 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 #8 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 ***Accept***

"No Objection Statements" were signed and present (see attached) per the Assessment plan.

The signature block of the community's SDCU resident-come contract has been revised to include a no objection statement. The contract is to be executed by all parties prior to admission and a new contract shall be executed prior to transfers within the community. For new move ins and transfers, the community will ensure the SDCU-specific Move In Checklist identifying paperwork and timeline requirements had been completed.

The Operations Leader conducts periodic Operations Audits which include a review of the Move In Checklist.

Completion Date: *03/24/2022*

Document Submission ***Implemented***

Completed

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# was taken to the Emergency Room via ambulance. The home did not report this incident to the department.

Resident #2 fell in the bathroom while trying to use the toilet. The resident was injured and was transported to the hospital. This happened sometime around late [redacted]r or early [redacted] The home did not report this incident to the department.

Repeat Violation: 2/25/21 et al.

Plan of Correction ***Directed***

Nursing staff on-duty were responsible for writing, documenting, communicating and submitting incident reports failed to do so and are no longer employed with the community as of [redacted] 2021 and [redacted] 2022, so retraining is not possible for these staff members.

The new GM (as of [redacted] 2022) and new HWD will ensure all required reporting is submitted within the 24-hour timeframe.

DPOC - SP - 04-01-2022
Within 15 business days of receipt of this POC, the administrator shall update or develop a policy on submitting written incident reports to the Department within 24 hours. Policy shall include timelines and who is responsible for submitting the incident report. The administrator will be responsible for reviewing the policy annually. Designated staff shall be trained of the policy update/development within 20 business days receipt of this POC. Documentation of the policy and staff training shall be provided to the Department for review within 25 business days of receipt of this POC.

Completion Date:

Document Submission ***Implemented***

Per instruction will provide updated policy by 4/16/22; training to be completed by 4/21/22; and documentation of policy and staff training provided by 4/25/22.