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

June 20, 2023

[redacted]
COLUMBIA/WEGMAN SOUTHAMPTON,LLC
[redacted]

RE: THE PROVINCE 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 04/24/2023, 04/25/2023 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: *THE PROVINCE OF SOUTHAMPTON* **Licen e #**: *14538* **Licen e Expiration**: *06/28/2023*

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

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

Administrator

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

Legal Entity

Name: *COLUMBIA/WEGMAN SOUTHAMPTON,LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-1* **Date**: *10/10/2019* **Issued By**: *Upper Southampton Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *68* **Waking Staff**: *51*

Inspection Information

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

Reason: *Renewal, Provisional, Fine* **Exit Conference Date**: *04/25/2023*

Inspection Dates and Department Representative

04/24/2023 - On-Site [redacted]

04/25/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

Licen e Capacity: *106* **Re ident Served**: *37*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *OPAL* **Capacity**: *36* **Re ident Served**: *12*

Hospice

Current Re ident : *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: *31*

Have Physical Disability: *1*

Inspections / Reviews

04/24/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/19/2023*

Inspections / Reviews *(continued)*

05/22/2023 - **POC Submission**

Submitted By: [redacted] **Date Submitted:** *06/15/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/21/2023*

06/14/2023 - **Document Submission**

Submitted By: [redacted] **Date Submitted:** *06/15/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *06/21/2023*

06/20/2023 - **Document Submission**

Submitted By: [redacted] **Date Submitted:** *06/15/2023*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted]/23, at [redacted]AM, caregivers observed resident 1 standing with their back against the wall outside their room. Resident 1 then stated another resident punched them into the wall. This incident was reported to staff person A. However, this allegation of abuse was not immediately reported in accordance with the Older Adult Protective Services Act.

Plan of Correction ***Accept ([redacted] - 05/19/2023)***

RHCD conducted In Service with HCD and RD on 4/25/23. HCD then conducted In Services with ACHD, MOD's, and care staff 5/1/23 and 5/2/23 to educate on reporting any suspected or witnessed abuse immediately to HCD, RD or AHCD and/or designated person(s), and providing initial written reports to DHS and AAA within 24 hours of incident occurring.

Forms and information on reporting were placed in MOD binder in the Copy Room behind front desk on 4/28/23.

Effective 4/28/23, RD, HCD and AHCD and/or designated person(s)are responsible for ensuring final reporting is completed and forwarded to both agencies within the 24 hr timeframe as well as to internal RDO and RHCD as applicable.

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented [redacted] 06/15/2023)

96a - First Aid Kit

2. Requirements

2600.
96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 4/25/23 at 10:10AM, The first aid kit in the health and wellness director's office did not include eye coverings, thermometer, gloves and tweezer.

Plan of Correction ***Accept [redacted] - 05/19/2023)***

On 4/25/23 HCD conducted inventory on first aid kits in community and updated supplies to complete the kits.

In-Services were conducted on 4/27 and 4/28/23 for care staff on the locations, contents and indications for use of first aid kits. Instructed on process for reporting use of first aid kit to AHCD, HCD or designated person(s) on replacing items used.

Effective 5/1/23 HCD, AHCD or designated persons are responsible for replacing used items and ensuring kits are complete.

Licensee's Proposed Overall Completion Date: *05/18/2023*

96a - First Aid Kit *(continued)*

Implemented [redacted] 06/15/2023)

131f - Fire Extinguisher Inspection

3. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguishers in the van and bus were not tagged for inspection by a fire safety expert.

Plan of Correction ***Accept ([redacted] 05/19/2023)***

2023 Inspection tags were inadvertently separated from the extinguishers.

ire Safety Company, Oliver, re inspected extinguishers on 4/28/23 and attached new tags to the extinguishers in company van and bus.

Effective 5/1/23 Life Enrichment Coordinator (LEC) and/or designated drivers are responsible for ensuring tags are in place on all community vehicles during pre trip vehicle inspections. Should any tags be badly damaged or missing, they are to report to Maintenance Director immediately so they may be replaced.

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented [redacted] - 06/14/2023)

132c - Fire Drill Records

4. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the drill conducted on [redacted] 23 at [redacted] PM does not include the exit route used and the amount of time it took for evacuation.

The fire drill record for the drill conducted on [redacted] /23 does not include the time of the fire drill.

Plan of Correction ***Accept ([redacted] - 05/19/2023)***

RD conducted In-Service with Maintenance Director on 5/1/23 on regulation 132c and importance of documenting all required information. Drill log updated on 5/1/23 by RD and Maintenance Director to notate required nformation.

Maintenance Director and/or designated person(s) responsible going forward for all fire drills and logs being fully complete. Fire Safety Vendor, Fire & Life Safety Solutions conducted a 2:00 am fire drill on 4/27 to meet bi-annual requirement of overnight drill with all data properly recorded as outlined in regulation 132c.

132c - Fire Drill Records (continued)

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented [redacted] 06/15/2023)

187b - Date/Time of Medication Admin.

5. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident 2 is prescribed [redacted], and [redacted]. Resident 2's medication administration record does not include the initials of the staff person who administered these medications on [redacted]/23 at 5PM.

Plan of Correction ***Accept ([redacted] - 05/19/2023)***

RAII was locked out of the electronic MAR system on 4/21/23 - failed to report the administration of the meds on paper MAR.

HCD conducted In-Service with all Med-Techs (RA II's) on 4/27 and 4/28 on printing and utilizing paper MAR's in the event the electronic MAR system is unavailable.

Effective 5/1/23, HCD and AHCD or designated person(s) will conduct daily monitoring to review the details of the medication variance report for errors.

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented [redacted] - 06/14/2023)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident 2 is prescribed [redacted] 10mg take one capsule by mouth once daily. However, resident 2 was not administered this medication on [redacted]/23.

Resident 3 is prescribed [redacted] Tab take 1 tablet by mouth once daily. However, resident 3 was not administered this medication on [redacted]/23.

Plan of Correction ***Accept ([redacted] 05/19/2023)***

Res 2 citation: On 4/26 all charts were audited by RHCD, HCD and AHCD to ensure there were no holes in the paper MARs from 3/1 thru 3/2/23. There was a change in dose; no administration and no note on record. HCD re-educated Med Techs on 4/27 & 4/28/23 re: policy and process to report missed meds.

Res 3 citation: During company transition and temporary unavailability of electronic MAR - Med Tech did not

187d - Follow Prescriber's Orders (continued)

record missed med. HCD conducted an In-Service with Med Techs on 3/13 and 3/14/23 due to error being previously dentified on 3/1 and 3/2, and charts were re-audited 4/26 by RHCD, HCD and AHCD.

Effective 5/1/23, HCD and AHCD or designated person(s) will conduct daily monitoring to review the details of the medication variance report for errors.

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented (- 06/15/2023)

231c - Preadmission Screening

7. 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 4 was admitted to the Secure Dementia Care Unit (SDCU) on /23. However, the resident 4's written cognitive preadmission screening was not signed by the assessor.

Plan of Correction ***Accept 05/19/2023)***

On 4/26/23 RHCD, HCD and AHCD conducted audit of all pre-screenings to ensure all were reviewed and signed. RHCD conducted an In-Service on 4/26/23 with HCD and AHCD on fully completing pre-screening assessment.

Effective 5/1/23, HCD and AHCD, or designated person(s) are responsible for verifying pre-screen documentation is complete and signed prior to resident move-in."

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented (- 06/15/2023)

233c - Key-Locking Devices

8. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

The directions for operating the home's locking mechanism are not conspicuously posted near the door to the Secure Dementia Care Unit (SDCU) at stairwell 3 and the courtyard. At stairwell 3, the incorrect code was posted and the door could not be opened with the posted code. The code to exit into the courtyard was scraped and unreadable.

Plan of Correction ***Accept - 05/19/2023)***

On 4/25/23 - RD replaced correct codes/directions for opening any/all Exit doors in the SDCU on the keypad next to each Exit door.

233c - Key-Locking Devices (continued)

Effective 4/26/23 RD, MOD and/or designated persons will check Exit Door codes as part of daily ""walk throughs"" of the community. Should a code be unreadable or missing RD, MOD and/or designated person will have the code replaced immediately.

Licensee's Proposed Overall Completion Date: *05/18/2023*

Implemented [redacted] - 06/14/2023)