Department of Human Services
Bureau of Human Service Licensing

September 13, 2021

CEO

RE: ELMCROFT OF STATE COLLEGE
150 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 23374

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/26/2021, 05/27/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Human Services Licensing Supervisor

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: *ELMCROFT OF STATE COLLEGE* **License #**: *23374* **License Expiration Date**: *07/03/2021*
Address: *150 FARMSTEAD LANE, STATE COLLEGE, PA 16803*
County: *CENTRE* **Region**: *NORTHEAST*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *EC OPCO SC LLC*

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/02/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *52* **Waking Staff**: *39*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *05/27/2021*

Inspection Dates and Department Representative

05/26/2021 - On-Site:
05/27/2021 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *32*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *na* **Capacity**: *20* **Residents Served**: *14*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *32*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *20* **Have Physical Disability**: *0*

Inspections / Reviews

05/26/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/10/2021*

7/12/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *07/15/2021*

7/26/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/02/2021*

9/13/2021 - Document Submission

Lead 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 /21, a report was made to the Aging Office of an allegation of abuse that took place on /21 between resident #1 and resident #2

Plan of Correction **Accept**

5-19-20 and 6-16-21 Administrator re-educated all staff on need to immediately report all and any allegation of abuse to protective services and all staff reminded on the locations of posters with protective service phone number in the community.

Administrator and/or designee will continue to educate staff on immediate reporting of abuse to Protective Service in the July and August all-staff meetings in 2021, and in the first 40 hours of all new hires and then at minimum annually for all staff.
Re-education will include identifying and preventing abuse, reporting obligations, internal/external reporting protocols for appropriate staff, and compliance line information (postings reviewed during orientation and all-staff meetings).

All staff will also be re-educated on the Code of Conduct, which will be completed by August 31, 2021

Administrator and/or designee will interview 5 different staff x 3 months on timely incident reporting as well as periodically review education during all-staff meetings until the end of 2021.

Results of monitoring will be reported at the monthly QA meetings for three months, and then quarterly for a year thereafter. Any discrepancies identified will be addressed as appropriate.

Completion Date: *08/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

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).

16c - Written Incident Report *(continued)*

Description of Violation

In ████/20 at ███pm, the home was notified by hospital that resident #3 was positive for a left hip fracture. However, the home did not report this to DHS until ████/20 @ ███pm.
On ███/21, an incident of alleged abuse took place between Resident #1 and Resident number #2. However, the incident was not reported to DHS within 24 hours of the incident. The incident occurred at ███ pm on ███/21 but was not reported to the Department until ███/21 at 8:15pm
On ███/21 @███ pm, Resident #4 was administered the wrong dosage of a medication and it was administered at the wrong time. However, this error was not reported to DHS until ███/21 @███pm.

Plan of Correction **Accept**

Administrator will re-educate all community leadership and all staff on the requirement for timely reporting within 24 hours to the department of human services by 7-31-21.

Re-education for all staff will be conducted in July and August, and in the first 40 hours of all new hires and then at minimum annually for all staff. Re-education to include identifying and preventing abuse, reporting obligations, internal/external reporting protocols for appropriate staff, compliance line information (postings reviewed during orientation and all-staff meetings), and location of posters with Protective Services hotline and timeframe of reporting posted in the community.

All staff will also be re-educated on the Code of Conduct, which will be completed by August 31, 2021.

Administrator and/or designee will monitor for timely reporting compliance and timeliness of all state reportable incidents will be reviewed at monthly QA meeting. Any discrepancies identified will be addressed as appropriate.

Completion Date: *08/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 - ███

Document Submission **Implemented**

Please see attached proof of staff training

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 Pennsylvania care facility carbon monoxide alarm standard act indicated that carbon monoxide detector batteries are to be checked annually and dated when that occurs. The batteries in the CO2 detectors located near the fireplace and in the kitchen were not dates. The home compliance with changing the batteries could not be measured.

18 - Compliance With Laws *(continued)*

Plan of Correction **Accept**

5-27-21 Maintenance Director changed battery in CO2 detector near fireplace and in kitchen and put dates on both.

All CO2 detectors will be audited by Maintenance Director 7-15-21 to verify date change stickers on all in community.

Administrator will re-educate community leadership team on regulation 2600.18 by 7-31-21

Administrator and/or designee will check CO2 detectors on quarterly basis for 1 year.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 - ██

Document Submission **Implemented**

Please see attached proof of staff training

65g - Annual Training Content

1. **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 person A, B, C, and D did not receive training in Instructions on meeting the needs (DME and RASP) during training year 2019.

Plan of Correction **Accept**

Administrator is contacting the fire expert to conduct training onsite by September 30
Administrator and/or designee will audit all current employees' training files to confirm that fire safety was completed by 7-31-21.
Administrator will re-educate community leadership responsible for verifying annual Fire Safety training on Regulation 2600.65.g by 7-31-21
Administrator and/or designee will periodically monitor staff training to verify all staff trained annually by fire expert.

Completion Date: *09/30/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 - ██

Document Submission **Implemented**

Fire safety training is scheduled for 09.15.2021

85d - Trash Receptacles

1. **Requirements**

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

Trash can in the activities room, next to the refrigerator, was not covered.

Plan of Correction **Accept**

5-27-21 Staff covered trash can in the activity room near the stove with a lid.

Administrator will re-educate all staff by 7-31-21 on need for all trash cans in bathrooms and common areas must have lids.

A member of community leadership or designee will walk community periodically to verify compliance with covered receptacles in bathrooms and kitchen.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

103i - Outdated Food

1. **Requirements**

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

There was an unlabeled, undated loaf of raisin bread in the memory care refrigerator.

Plan of Correction **Accept**

5-27-21 undated bread disposed of by administrator at time of inspection.
Administrator will re-educate all staff on Reg 103i by July 31, 2021
Dining service director or designee will monitor for compliance and reviewed during monthly QA meeting. Any discrepancies identified will be addressed as appropriate.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

121a - Unobstructed Egress

1. **Requirements**

2600.

121a - Unobstructed Egress *(continued)*

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Repeat Violation

On 5/27/21, at 11:00am, the door leading to the back patio, which is also a fire exit, was blocked by an umbrella stand. The stand prohibited the door from fully opening.

Plan of Correction **Accept**

5-27-21 Umbrella was moved at time of finding by Maintenance Director.

Administrator will re-educate all staff on importance of keeping all egress clear and unobstructed at all times by 7-31-21. Administrator will review at monthly all-staff meetings for next two months beginning after July's meeting.

Maintenance Director and/or designee will review with all new hires during orientation.

Administrator will review with residents regarding the need for unobstructed egress at July's Resident Council meeting, to be completed by 7-31-2021

Maintenance Director and/or designee will monitor all egress routes for unobstructed egress on a periodic basis. Monitoring will be reviewed during monthly QA meeting. Any discrepancies identified will be addressed as appropriate.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

141b1 - Annual Medical Evaluation

1. **Requirements**

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #5's most recent medical evaluation was completed on 2 . The resident's previous medical evaluation was completed on .

Plan of Correction **Do Not Accept**

On 7/9/21, Administrator spoke with , Licensing Director, who noted that regulation 2600.141.b.1 is suspended and should not be cited.

Completion Date: *07/09/2021*

Update - 07/12/2021

Limited, not total suspension. Please submit an acceptable plan of correction
7-12-2021 -

141b1 - Annual Medical Evaluation *(continued)*

Plan of Correction **Accept**

Audit of all current DMEs will be conducted to verify they are done annually by 7-31-21. Tickler system created to track when annual DMEs are due.

Administrator will re-educate nursing staff on the requirement that all residents must have an annual medical evaluation completed by 7-31-21.

Administrator and/or designee will monitor for timely completion of all DMEs moving forward after audit completion with assistance of tickler system and will be reviewed monthly at QA meeting.

Completion Date: *07/31/2021*

Update - 07/26/2021

please send/Attach proof of staff training. 7-26-2021 ■

Document Submission **Implemented**

Please see attached proof of staff training

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 Repeat Violation

The home did not properly maintain the Medication Administration Record (MAR) of the indicated resident due to staff incorrectly transcribing of the blood glucose test results in the individual glucometer. Resident #7 – At 5pm on 5/20/21, the reading on the glucometer was 423 but was incorrectly transcribed as 429. Resident #8 – At 12pm on 5/14/21, the reading on the glucometer was 87 but was incorrectly transcribed as 81.

Plan of Correction **Accept**

7-9-21 Glucometer logs started at end of shift to verify glucometer reading and MAR entry are correct and will be reviewed weekly by nurse and or designee

Nurse will re-educate all nurse and medication technicians on importance of accurate documentation by 7-31-21 and will review biannually with all medication technicians.

Nurse and/or designee will monitor glucometer reading and MAR for proper documentation with weekly MAR and medication cart audits and be reviewed monthly at QA meeting. Any discrepancies identified will be addressed as appropriate.

Completion Date: *07/31/2021*

185a - Implement Storage Procedures *(continued)*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

225a - Assessment 15 Days

1. **Requirements**

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Repeat Violation

The initial assessment for resident # 5 was completed which is prior to the residents admission date of

Correction **Accept**

An audit of all current residents' initial assessment will be conducted to verify assessment is completed within 15 days of physical move in by 7-31-21.

Administrator will re-educate nursing staff on timeliness of completing assessment once physically move in by 7-31-21.

Nurse and/or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually.

Administrator and/or designee will monitor all new move in to verify assessment completed within 15 days of physical move in.
Monitoring will be reviewed at the weekly Quality Care review meeting with Administrator, Nurse, Activities, and Dining Services. Any discrepancies identified will be addressed as appropriate.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021

Document Submission **Implemented**

Please see attached proof of staff training

227a - Support Plan 30 Days

1. **Requirements**

2600.
227.a. A resident requiring personal care services shall have a written support plan developed and implemented within 30 days of admission to the home. The support plan shall be documented on the Department's support plan form.

Description of Repeat Violation

The initial support plan for resident # 5 was completed which is prior to the residents admission date of 12/21/18.

227a - Support Plan 30 Days *(continued)*

Plan of Correction **Accept**

An Audit of all current residents' initial support plan will be conducted to verify residents support plan/service plan is completed within 15 days of physical move in by 7-31-21.
Administrator will re-educate nursing staff on timeliness of completing support plan/service once resident physically moves in no later than 30 days of move-in by 7-31-21.
Nurse and/or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually.

Administrator and/or designee will monitor all new move-ins to verify support plan completed within 30 days of physical move-in.
Monitoring will be reviewed at the weekly Quality Care review meeting with Administrator, Nurse, Activities, and Dining Services. Any discrepancies identified will be addressed as appropriate.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training

227g -Support Plan Signatures

1. **Requirements**

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #6 participated in the development of his/her support plan on 4/6/20. However, the resident did not sign the support plan.

Plan of Correction **Accept**

Resident #6 will sign support plan by 07-16-2021
An audit of all current residents' support plan will be conducted to verify signatures by 7-31-21.
Administrator will re-educate nursing staff on having all individuals who participate in development of support plan need to sign and date the support plan by 7-31-21.
Nurse and/or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually.
Administrator and/or designee will monitor all new support plan to verify signatures.
Monitoring will be reviewed at the monthly QA meeting.

Completion Date: *07/31/2021*

Update - 07/12/2021

Please send/Attach proof of staff training. 7-12-2021 -

Document Submission **Implemented**

Please see attached proof of staff training