Department of Human Services
Bureau of Human Service Licensing

October 9, 2021

[redacted], PRESIDENT
EC OPCO LOYALSOCK LLC
5885 MEADOWS ROAD, SUITE 500
ECLIPSE SR LIV ATTN LICENSING
LAKE OSWEGO, OR 97035

RE: ELMCROFT OF LOYALSOCK
2985 FOUR MILE DRIVE
MONTOURSVILLE, PA, 17754
LICENSE/COC#: 22719

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/29/2021, 06/30/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]
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 LOYALSOCK* **License #:** *22719* **License Expiration Date:** *07/03/2022*
Address: *2985 FOUR MILE DRIVE, MONTOURSVILLE, PA 17754*
County: *LYCOMING* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/22/1999* **Issued By:** *L&I*

Staffing Hours

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

Inspection

Type: *Full* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Renewal* **Exit Conference Date:** *06/30/2021*

Inspection Dates and Department Representative

06/29/2021 - On-Site: [redacted]
06/30/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *90* **Residents Served:** *32*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *32*
Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *10* **Have Physical Disability:** *0*

Inspections / Reviews

06/29/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/23/2021*

9/28/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *10/10/2021*

10/9/2021 - Document Submission

Lead 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

The batteries in the carbon dioxide monitor located in the lobby area were last changed in February 2020. According to the Care Facilities Carbon Monoxide Monitoring act, the batteries must be replaced annually.

Plan of Correction **Accept**

Action: Batteries replaced in lobby carbon monoxide detector on 6.30.2021 by Maintenance director. An Audit of all Carbon Monoxide detectors will be audited to ensure all batteries have been changed annually by 10.15.21.
Training: 09.15.2021 Administrator/Operation Specialist Training completed with Maintenance Director that batteries need changed annually
Ongoing: Maintenance Director or designee will ensure batteries are changed annually.
Executive Director/designee will monitor compliance

Completion Date: *10/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021- [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.

65a - FS Orientation 1st Day

1. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A's first day of work was [redacted]*. Staff person A was not trained in the topics required under this regulation until* [redacted]*.*

65a - FS Orientation 1st Day *(continued)*

Plan of Correction **Accept**

Training: 9.15.2021 Administrator/designee will educate all members of leadership on Reg. 65a
All New hires will have a completed Pre-employment Checklist by Business Office Coordinator /designee prior to first day orientation.
Ongoing: Administrator/designee will review all new hires paperwork for compliance monthly at quality assurance meeting

Completion Date: *09/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. - 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.

Description of Violation

Staff person B did not receive training on resident rights for the training year 2019.
Staff person C did not receive training in fire safety by a fire safety expert for the year 2019.

Plan of Correction **Accept**

Action: Audit of all current associates training file will be conducted to ensure all have received annual training on regulation 65g by 10.15.2021
Training: 9.15.2021 Administrator/operation Specialist educated Nurse and Business coordinator on regulation 65g
Ongoing: Administrator/designee will review all new hires paperwork for compliance monthly at quality assurance meeting

Completion Date: *10/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.

103i - Outdated Food

1. Requirements

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

Description of Violation

The home's pantry adjacent to the kitchen contained 4 large dented cans stored along with other canned foods in the rotation for use. There were 3 cans of spaghetti sauce and 1 can of stewed tomatoes.

Plan of Correction **Accept**

Action: 6.29.21 All dented cans were removed by dining service director.
Training: Administrator/Operation Specialist will re-educate all staff that any dented cans must not be used and must not be stored with other canned foods by 9.30.2021.
Ongoing: Administrator/designee will monitor cans for compliance

Completion Date: *09/30/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21 with leadership and 9/22/21 with all staff.

107d - Procedure Emergency Management Agency Submission

1. Requirements

2600.
107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home did not have documentation that their emergency procedures were reviewed and sent to the local emergency management agency in 2020 or 2021.

Plan of Correction **Accept**

Action: 9.15.2021 Administrator sent Emergency response plan to Local emergency management agency and waiting for confirmation of receipt by 9.30.21
Training: 9.15.2021 Administrator/Operation Specialist educated all members of leadership team on Emergency Response Plan needs to be reviewed by local emergency management agency annually.
Ongoing: Administrator/designee will monitor compliance.

Completion Date: *09/30/2021*

Update - 09/28/2021

Please send/Attach proof of compliance with this regulation. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21. Received confirmation on 9/22/21 from Loyalsock County Department of Public Safety.

132h - Designated Meeting Place

1. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Fire drill logs indicate that during the fire drill conducted on 12/20/2019 at 11am 1 resident refused to leave [redacted] room during the drill.

Plan of Correction **Accept**

Training: Administrator/Operation Specialist will educate all staff on fire drills and that resident must evacuate during fire drills by 9.30.2021.

Ongoing: Administrator/designee will monitor compliance by reviewing fire drill log monthly at quality assurance meeting.

Completion Date: *09/30/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21 with leadership and 9/22/21 with all staff.

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

The Documentation of Medical Evaluation (DME) form dated [redacted] for resident #1 was missing the pulse rate. The DME form dated [redacted] for resident #2 was missing the weight.

141a 1-10 Medical Evaluation Information *(continued)*

Plan of Correction **Accept**

ACTION: New DME for resident #1 was completed [redacted], Resident #2 new DME was completed on [redacted]
Audit of all current residents DME's for completeness by [redacted]
TRAINING: 9.15.2021 Administrator/Operation Specialist educate leadership team on regulation 2600.141a2 that DME must be completed with all information
Nurse and or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually on regulation 141.a
ONGOING: Administrator/designee will review new DME's for completion prior to filing in residents' chart for compliance.

Completion Date: *10/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.

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 Violation

The support plan dated [redacted] for resident #3 was not finalized until [redacted]

Plan of Correction **Accept**

Training: 9.15.2021 Administrator/Operation Specialist educate nursing staff on support plan/service plan is completed within the 30 days of admission.
Nurse and or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually on regulation 227a.
Ongoing: Administrator and/or designee will monitor all support plans to verify all support plans are completed within 30 days of admission. Support plan will be reviewed at the weekly Quality Care meeting.

Completion Date: *09/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.

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.

227g -Support Plan Signatures *(continued)*

Description of Violation

Resident #1 was admitted to the home on [redacted]. Resident #1 had a support plan completed within 30 days of admission but the support plan was not signed by the resident or by the person who completed the assessment.

Plan of Correction **Accept**

Training: 9.15.2021 Administrator/Operation Specialist educated nursing staff that resident and creator must sign support/service plan.
Audit of all current resident's support plans for signatures by 10.15.21.
Nurse and or designee will educate any newly hired nursing staff during orientation, and all nursing staff annually on regulation 227g.
Ongoing: Administrator and/or designee will monitor all new support plans to verify all are signed by resident and creator.

Completion Date: *10/15/2021*

Update - 09/28/2021

Please send/Attach proof of staff training. 9-28-2021 [redacted]

Document Submission **Implemented**

Attached documentation for staff training completed on 9/15/21.