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

October 18, 2023

[redacted]
EC OPCO SC LLC
[redacted]

RE: CELEBRATION VILLA OF NITTANY VALLEY
150 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 23374

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/13/2023 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: *CELEBRATION VILLA OF NITTANY VALLEY* **License #**: *23374* **License Expiration**: *07/03/2024*

Address: *150 FARMSTEAD LANE, STATE COLLEGE, PA 16803*

County: *CENTRE* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *EC OPCO SC LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *08/02/2010* **Issued By**: *Centre County Region*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *56* **Waking Staff**: *42*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *09/13/2023*

Inspection Dates and Department Representative

09/13/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *36*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1st flr* **Capacity**: *20* **Residents Served**: *18*

Hospice

Current Residents: *15*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *36*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *20*

Have Physical Disability: *0*

Inspections / Reviews

09/13/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/13/2023*

10/12/2023 - POC Submission

Submitted [redacted] **Date Submitted**: *10/18/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *10/15/2023*

Inspections / Reviews *(continued)*

10/18/2023 - Document Submission

Submitted By: [redacted] **Date Submitted**: *10/18/2023*

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

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident # 1, contract dated [redacted] 2022 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

ACTION: On September 14, 2023, Administrator reviewed contracts with resident #1 and had them sign contract for missing signature. Administrator and/or administrative assistant will complete an audit of all resident charts by 10.30.2023 for all appropriate signatures.
TRAINING: On October 3, 2023, the community leadership team were trained on Regulation 2600.25b by the Administrator.
ONGOING: Starting with any admission from 10-11-23 on Administrator or a member of leadership will review contracts for completeness and all appropriate signatures.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 10/18/2023)

41e - Signed Statement

2. Requirements

2600.
41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1 and #2 do not have signed Resident Rights Forms.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

ACTION: On September 14, 2023, the Administrator reviewed resident rights with resident #1 and #2 who did not have signatures on file. Residents' signatures were obtained on 09.14.2023. The administrator and/or administrative assistant will complete an audit of all resident record charts by 10.30.2023 to ensure resident rights have been signed by the resident.
TRAINING: On 10/3/23, Administrator and Administrative assistant reviewed DHS Regulation 2600.41.e with community leadership staff.
ONGOING: Administrator and/or administrative assistant will complete an audit of all resident charts by 10.30.2023 for compliance. The leadership team will review audit at the monthly Quality Assurance meeting in November 2023.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 10/18/2023)

65f - Training Topics

3. Requirements

65f - Training Topics *(continued)*

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
5. Personal care service needs of the resident.

Description of Violation

Direct care staff person A did not receive training in meeting the needs (DME/RASP), care for residents with dementia and cognitive impairment, and personal care service needs of the resident during training year 2022.

Plan of Correction ***Accept [redacted] 10/12/2023)***

ACTION: On September 20, 2023, Training logs of all staff for the calendar year were reviewed by ED, DON, ADON. Staff member A is currently completing any required training.
TRAINING: On September 21, 2023, all staff were trained on Regulation 2600.65.f by the Administrator.
ONGOING: Starting 10-9-23 Administrator and/or administrative assistant will monitor all staff training monthly to ensure annual training requirements are being met and will be reviewed at monthly quality assurance beginning with October 2023 meeting.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented ([redacted] - 10/18/2023)

101j7 - Lighting/Operable Lamp

4. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Room 209 does not have a light source that can be reached from the bedside.

Plan of Correction ***Accept [redacted] - 10/12/2023)***

ACTION: On September 13, 2023, A push button light was immediately placed at the resident's bedside on 09.13.2023 by Administrator.
TRAINING: On September 21, 2023, All staff were trained on regulations 2600.101.j a by the Administrator.
ONGOING: Maintenance director will verify upon the day of each resident move in that the resident has an operable lamp or other source of light at bedside. Monthly audits will be conducted by the maintenance director starting October 9, 2023. The leadership team will review audits at the monthly Quality Assurance Metting starting in October 2023.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 10/18/2023)

103i - Outdated Food

5. Requirements

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

103i - Outdated Food *(continued)*

Description of Violation

The freezer inside the Kitchen Door had a wrapped muffin without a label or date.

Plan of Correction ***Accept (- 10/12/2023)***

ACTION: On September 13,2023 wrapped muffin was immediately removed and thrown away, at the time it was found during the DHS inspection, by the Administrator.
TRAINING: On September 21, 2023, Regulation 2600.103.i was reviewed with all staff by the Administrator.
ONGOING: Dietary director and/or cook will check refrigerator at end of each day, for four weeks to ensure compliance that all food is labeled/dated as required beginning October 9, 2023. Then Administrator or member of leadership will do random weekly checks. Results of checks will be reviewed at monthly Quality assurance meeting beginning in November of 2023.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented - 10/18/2023)

132a - Monthly Fire Drill

6. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

A fire drill was not conducted in May 2022.

Plan of Correction ***Accept - 10/12/2023)***

Action: An unannounced fire drill was conducted on 9/14/2023 by maintenance director.
TRAINING: On October 3, 2023, Regulation 2600.132.a was reviewed by all leadership team by Administrator.
ONGOING: Starting October 9, 2023, Unannounced fire drills will be held monthly. This will be documented at each drill by our maintenance director and verified by the Administrator for accuracy each month. The leadership team will review fire logs at the monthly Quality Assurance Metting starting in October 2023.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented (- 10/18/2023)

132h - Designated Meeting Place

7. 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

The fire drill conducted on 7/22/2022 had 37 residents in the home, only 9 residents were evacuated.

Plan of Correction ***Accept (- 10/12/2023)***

Action: On September 14, 2023 An unannounced fire drill was conducted by maintenance director. All residents were accounted for and evacuated to fire-safe areas.
TRAINING: On September 21, 2023, all staff were re-educated on Regulation 2600.132.h by the Administrator.
ONGOING: Fire drill will be conducted monthly as required. All residents in the home will be evacuated to appropriate designated areas or from the building. Maintenance or a member of leadership to verify at each drill

132h - Designated Meeting Place (continued)

all residents are evacuated. Starting in October 2023 the Administrator will monitor evacuation compliance to designated area and fire drill record reviewed at the monthly Quality Assurance Meeting.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented [redacted] - 10/18/2023)

144c2 - Smoking Area Distance

8. Requirements

2600.
144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:
2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

The employee smoking area is behind the building next to the dumpsters. The cigarette urn was approximately 2 feet from the dumpster and approximately 8 feet from upholstered furniture that was being disposed, posing a possible fire hazard.
There were multiple cigarette butts in the mulched area outside the front door, posing a possible fire hazard.

Plan of Correction ***Accept ([redacted] - 10/12/2023)***

ACTION: On September 13, 2023, Smoking area was immediately moved during DHS inspection to more than 25 feet from dumpster/home and ground area cleaned up by Maintenance Director.
TRAINING: On September 21, 2023, all staff educated on Regulation 2600.144.c and new location of smoking area by Administrator and Maintenance Director. A member of Leadership will train all new staff on Regulation 2600.144.c and designated smoking area within first week of hire.
ONGOING: Starting 10-10-23 Administrator, Maintenance Director, or a member of leadership will walk the ground daily to ensure compliance.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented ([redacted] - 10/18/2023)

187d - Follow Prescriber's Orders

9. Requirements

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

Description of Violation

Resident #3 is prescribed the following medications to be administered at 8.00pm: Iron 325mg, folic acid 100mcg, melatonin 3mg, metoprolol 50mg, pantoprazole 40mg, senexon-s 8.6/50mg, vitamin D3 400 units, and vitamin b12 500mcg. These medications were not available on 1/28/23 and 1/29/23 and were not administered as prescribed.
Resident #4 is prescribed the following medications for 7:00pm: Carvedilol 6.25mg, Colace 100mg, Gabapentin 300mg, Donepezil 10mg, Melatonin 3mg, Oscal/Vitamin D 500mg/5mcg, and Trazadone 50mg. The medication was not available in the home on 1/30/23 and 1/31/23 and therefore was not administered as prescribed.

187d - Follow Prescriber's Orders *(continued)*

Plan of Correction ***Accept (- 10/12/2023)***

Action: In January 2023 physician and families were notified and state reportable was submitted.
An audit of Residents MAR was conducted 10/06/2023- 10/09/2023, by the Assistant Director of nursing ensure prescriber orders are being followed and available in cart
TRAINING: Administrator and Director of Nursing Reviewed Regulation 2600.187.d, proper medication administration cycle and community medication policies with All Nurses and current medication technicians October 6 and October 7, 2023.
ONGOING: -Starting October 9, 2023, Director of Nursing and/or member of community leadership will perform weekly medication audit. Results of audit will be reviewed at monthly Quality assurance meeting

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented - 10/18/2023)

227d - Support Plan Medical/Dental

10. 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

Resident # 2 Documentation of Medical Evaluation (DME) dated /2023 noted Resident #2 requires soft, bite sized food. The initial Resident Assessment and Support Plan (RASP) initial RASP dated or residents follow up RASP dated /2023 does not indicate the resident's dietary need.

Plan of Correction ***Accept - 10/12/2023)***

ACTION: On September 14, 2023, Resident 2 RASP was updated by the Administrator to address dietary needs. An audit of all current Residents RASP was done by Administrator and nurse to ensure all need in regulation 227d were address this was completed by9-30-23
TRAINING: On October 3, 2023, Regulation 2600.227.d was reviewed with nursing leadership team by the Administrator.
ONGOING: Starting 10-1-23 Administrator, Director of nursing and or a member of leadership will review all new RASP to ensure all needs of regulation .227d are captured and new RASP will be reviewed at monthly Quality Assurance Meeting beginning October 2023.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented 10/18/2023)

233c - Key-Locking Devices

11. 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 home has a secured dementia unit. The code to the keypad is not posted near the device on the inside of the unit.

233c - Key-Locking Devices *(continued)*

Plan of Correction ***Accept (- 10/12/2023)***

ACTION: Date of inspection 9-13- 2023 code to keypad was reposted to inside door of memory care by the Maintenance Director.

TRAINING: On 9- 23, 2023, all staff were trained on Regulation 233.c by the Administrator.

ONGOING: Starting October 9, 2023, the memory care coordinator and/or a member of leadership will walk memory care neighborhood daily to ensure code is posted at all doors.

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented - 10/18/2023)

236 - Staff Training

12. Requirements

2600.

236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Staff A did not complete 6 hours dementia care and services training for training year 2022.

Plan of Correction ***Accept (- 10/12/2023)***

ACTION: On September 20, 2023 an audit was conducted on 2023 dementia training. Staff member A is current for 2023 dementia training.

TRAINING: On September 21, 2023, all staff were trained on Regulation 2600.236 by the Administrator.

ONGOING: Starting October 10, 2023 Administrator and or a member of leadership team will monitor staff training monthly to ensure compliance of 6 annual hours of dementia training requirements/completion and will be reviewed at Quality Assurance Meeting starting in October 2023

Licensee's Proposed Overall Completion Date: *10/30/2023*

Implemented - 10/18/2023)