



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [REDACTED]

MAILING DATE: December 8, 2016

Ms. Ilise Rubinow, Administrator
Elan Gardens Inc.
465 Venard Road
Clarks Summit, Pennsylvania 18411

RE: Elan Gardens
License #: 243750

Dear Ms. Robinow:

As a result of the Department of Human Services' licensing inspection on November 1, 2016 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Michele Moskalczyk
Michele Moskalczyk
Regional Licensing Administrator

Enclosure
Licensing Inspection Summary

Violation Report: 24375 - 11/01/2016 - Rushin, Julianne
 PCH Name: ELAN GARDENS

1. REGULATION 55 Pa.Code §2600
 2600.42(c) - A resident shall be treated with dignity and respect.

2a. DESCRIPTION OF VIOLATION

The home's policy is that wheelchairs are not allowed in the dining room and a resident is to ambulate with his/her walker from the entrance of the dining room to their table. On 10/18/16 at approximately 9:22 am resident #1 was seated in his/her wheelchair and being wheeled to the entrance of the dining room by a private duty caregiver. Because the caregiver was unable to navigate the wheelchair, a walker and the O2 tank from the resident's room to the dining room, he/she asked staff person "A" if there was an extra walker available. Staff person "A" responded "no". The private duty caregiver described resident #1, who is receiving hospice services, as weak and non-weight bearing that day, so he/she needed assistance with safely transferring the resident to the table. At that point, staff person "A" stated "I'll walk him/her in" and without any warning or instruction to resident #1, roughly and abruptly lifted him/her under the arms from behind and "partially dragged" the resident to the chair. While still holding the resident under the arms from behind, staff person "A" started yelling loudly for resident #1 to place his/her hands on the table for support so staff person "A" could push the chair in. Both the private duty caregiver and another staff person that was standing close by, stated the resident appeared both "shocked and stunned". Resident #1 is extremely hard of hearing and could not follow staff person "A's" instructions. Seeing that resident #1 was startled and confused, staff person "B" guided the resident back onto the chair and pushed it closer to the table. The incident was observed by other residents who verbalized their disgust to the private duty caregiver later that day. Resident #1 was not treated with dignity and respect.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.


It is the philosophy and goal of Elan Gardens to treat its residents with dignity and respect. Staff person A has been counseled regarding this event and was put on a 10 day suspension from duties. He has been re-trained in the area of appropriately talking to and caring for residents with respect and dignity. While there is an annual inservice addressing dignity and respect, we are repeating it for all staff during the month of December. This will be a mandatory inservice training. The Quality Assurance Nurse is responsible for conducting inservice trainings and the Administrator is ultimately responsible for ensuring that all residents are treated properly. All staff members have been notified of the requirement of completing the inservice training and the final date for completion will be December 31, 2016. Subsequently that will be the date for the completion of this plan of correction although the Administrator will be responsible for ongoing monitoring of the way that residents are treated and handled.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Ilise Rubiner, Administrator Date 11/23/16

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>12/3/16</u> (Date)	Plan of correction Implementation status as of <u>12/3/16</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 24375 - 11/01/2016 - Rushin, Julienne
 PCH Name: ELAN GARDENS

1. REGULATION 55 Pa.Code §2600
 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.


2a. DESCRIPTION OF VIOLATION
 The annual RASP for resident #1 (dated 1/18/16) was not updated to indicate that he/she was receiving hospice services; had a private duty caregiver from a home health agency and was no longer independent with ambulation and transfers.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Attached is the addendum to the RASP which was presented at the time of inspection reflecting the addition of hospice services for resident #1. There were no updates to include private duty aides because this was done at the whim of the resident's family as opposed to a necessity determined by a medical professional. However, effective immediately, all private duty personnel within the facility, will be reflected on the individual residents' RASP. In addition, all changes in ambulation and transfers will be included in the RASP even when the need is intermittent as it was in the case of resident #1. Attention will be given to including all resident status changes on resident RASP's.

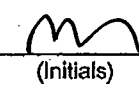
This will be the responsibility of the Quality Assurance Nurse and the RN Wellness Coordinator under the supervision of the Administrator who has final responsibility. This will be completed by December 1, 2016.

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <u>Elise Rubino, Administrator</u>	Date <u>11/23/16</u>
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