pennsylvania
DEPARTMENT OF HUMAN SERVICES

DEC 06 2018

Ms. Arlene Anderson
Administrator
Elk Haven Nursing Home Association, Inc.
785 Johnsonburg Road,
St. Mary's, Pennsylvania 15857

RE: Silver Creek Terrace
791 Johnsonburg Road,
St. Mary's Pennsylvania 15857
Certificate #: 426020

Dear Ms. Anderson:

As a result of the Department's Bureau of Human Services Licensing annual inspection on November 14, 2018, 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: SILVER CREEK TERRACE	**License Number:** 42602
Address: 791 JOHNSONBURG ROAD, ST MARYS, PA 15857	**County:** Elk
Administrator: Megan Schneider	**Region:** WEST
Legal Entity Name: ELK HAVEN NURSING HOME ASSOCIATION INC	
Legal Entity Address: 785 JOHNSONBURG ROAD, ST. MARYS, PA 15857	

Certificate(s) of Occupancy
C-2 LP
03/19/1997
L&I

RECEIVED
11/28/2018
Western Region Field Office
Bureau of Human Services Licensing

Staffing Hours

Resident Support: 0 **Total Daily Staff:** 55 **Waking Staff:** 41

Type of Inspection: Full **BHA Docket Number:** **Notice:** Unannounced

Reason(s) for Inspection(s)
Renewal

On-Site Inspections Dates and Department Representatives On-Site
11/14/2018: Spagna, Lauren; Mulick, Cindy

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: **Random Indicators:**

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 80	**Number of Residents who:**
Number of Residents Served: 51	**Receive Supplemental Security Income:** 3
Secured Dementia Care Unit in Home: No	**Are 60 Years of Age or Older:** 50
Area:	**Have Mental Illness:** 0
Secured Dementia Unit Capacity, if Applicable:	**Have an Intellectual Disability:** 0
Number of Residents Served in Secured Dementia Care Unit, if applicable:	**Have a Mobility Need:** 4
Number of Current Hospice Residents: 0	**Have a Physical Disability:** 1
Number of Hospice Residents in past year: 0	

Violation Report: 42602 - 11/14/2018 - Spagna, Lauren
PCH Name: SILVER CREEK TERRACE

Western Region Field Office
Bureau of Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION

The home's maximum safe evacuation time is 6 minutes, as indicated in writing by the fire safety expert, dated 9/26/17. However, the evacuation for the fire drill held on 7/15/18 at 11:30 pm was conducted in 7 minutes, 20 seconds.

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.

1. Failure to evacuate the residents to a fire safe area within 6 minutes was documented as a particular resident overly concerned with her clothing and would not proceed to fire safe area as directed. All other residents were in the fire safe areas within the 6 minute time period allotted. This drill was the resident's first fire drill upon admission.
2. Resident was educated on the importance of fire drills, the procedure to follow during fire drill, shown the interior fire safe area and exits of the facility, the importance of having a robe and slippers handy in the event of an emergency during sleeping hours and assessed for any mobility concerns for emergency purposes.
3. Direct Care Staff members were educated regarding education to the residents, regulations set forth by the Department of Human Services pertaining to fire drills, review of exits and fire safe areas and proper procedure and mobility and dignity concerns of the residents addressed.
4. A repeat sleeping hour fire drill was conducted on July 23, 2018 and all residents successfully made it to the designated fire safe areas in four minutes and forty-five seconds.
5. "House Rules," including participation in fire drills and locations of fire safe areas, are addressed with residents and designated person(s) during the Admission process by Administrator.
6. Continued compliance will be reviewed at monthly Quality Assurance Meetings.

Repeat Violation: No	**Date(s) of Previous Violation(s):**			

Signature of Legal Entity Representative (Required on EVERY Page) Arlene Anderson, NHA

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) ARLENE ANDERSON

Date 11/28/2018

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

The above plan of correction is approved as of 11/28/18 (Date)

The above plan of correction was approved by _____ (Initials)

Plan of correction implementation status as of 11/28/18 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress JM
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 42602 - 11/14/2018 - Spagna, Lauren
PCH Name: SILVER CREEK TERRACE

1. REGULATION 55 Pa.Code §2600

2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

(1) The resident's name.
(2) The name of the medication.
(3) The date the prescription was issued.
(4) The prescribed dosage and instructions for administration.
(5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION

Resident #1 is prescribed Novolog insulin-100u/ml-Inject subcutaneously before meals and at bedtime in accordance with sliding scale; however, the pharmacy label for the resident's Novolog does not include the sliding scale.

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.

1. The pharmacy was contacted on November 27, 2018 about requirement to include sliding scales on the insulin labels.
2. The pharmacy sent new labels for the resident's Novolog that include the sliding scale prescribed by physician.
3. Any future insulin labels will include sliding scales in the labeling as directed by physician.
4. Direct Care Staff members were educated on regulatory compliance with labeling and shown the new labels.
5. Continued compliance will be reviewed at monthly Quality Assurance Meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

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Printed Name and Title of Legal Entity Representative (Required on EVERY Page) ARLENE ANDERSON

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Violation Report: 42602 - 11/14/2018 - Spagna, Lauren
PCH Name: SILVER CREEK TERRACE

Western Region Field Office
Bureau of Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION

Resident #2's November 2018 medication administration record does not include the initials of the staff person(s) who administered the following medications to the resident on 11/4/18 and 11/12/18 at 7:00 am:

* Lotrisone Cream
* Voltaren-1% Gel

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.

1. Direct Care Staff members were notified of the discrepancies in the MAR documentation on November 27, 2018 by Administrator and Wellness Coordinator (trainer).
2. Direct Care Staff members who are trained to administer medications reviewed the proper policy and procedure for documentation of administration.
3. Direct Care Staff members who administer medications will conduct a self-review of documentation at the end of every medication pass and ensure accuracy that all Medication Rights were followed.
4. The facility Medication Administration trainer documents quarterly reviews and monthly MAR reviews to ensure accurate documentation.
5. Continued compliance will be reviewed during monthly Quality Assurance Meetings.

Repeat Violation: No	Date(s) of Previous Violation(s):			

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