



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail: tryhal@elmcroft.com
dbaker@ventasreit.com
licensing@eclipseseniorliving.com

MAILING DATE: January 9, 2020

Mr. Christian N. Cummings
President
EC OPCO Chippewa, LLC
Eclipse Sr. Living Attn: Licensing
5885 Meadows Road, Suite 500
Lake Oswego, Oregon 97035

RE: Elmcroft of Chippewa
104 Pappan Business Drive
Beaver Falls, Pennsylvania 15010
Certificate #: 449010

Dear Mr. Cummings:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 23, 2019 and October 29, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jon B. Kimberland".

Jon Kimberland
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Received BHSL
1/6/2020

Facility Information

Name: *ELMCROFT OF CHIPPEWA*
Address: *104 PAPPAN BUSINESS DRIVE,, BEAVER FALLS, PA 15010*
County: *BEAVER* Region: *WESTERN*

License Number: *44901*

Administrator

Name: *Theresa Ryhal* Phone: *7248913333* Email: *tryhal@elmcroft.com*

Legal Entity

Name: *EC OPCO CHIPPEWA LLC*
Address: *5885 MEADOWS ROAD, SUITE 500, ECLIPSE SR LIV ATTN LICENSING, LAKE OSWEGO, OR, 97035*

Certificate(s) of Occupancy

Type: <i>C-2 LP</i>	Date: <i>05/22/1999</i>	Issued By: <i>PA Dept L&I</i>
Type: <i>I-2</i>	Date: <i>03/18/2011</i>	Issued By: <i>Chippawa Twp</i>

Staffing Hours

Resident Support Staff: Total Daily Staff: *89* Waking Staff: *67*

Inspection

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

Inspection Dates and Department Representative

10/23/2019 - On-Site: Vicki Siegert, Courtney Barry, Trish Bartlett
10/29/2019 - On-Site: Vicki Siegert, Courtney Barry

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *85* Residents Served: *69*

Secured Dementia Care Unit

In Home: *Yes* Area: *Memory Care* Capacity: *20* Residents Served: *19*

Hospice

Current Residents: *19*

Number of Residents Who:

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>69</i>
Diagnosed with Mental Illness: <i>1</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>20</i>	Have Physical Disability: <i>1</i>

88a - Surfaces

Regulations

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 10/23/19 at approximately 10:15 a.m., there was a 5' high, 3-panel room divider blocking the approximately 20' long hallway that leads to the courtyard. This hallway connects to the main hallway near the employee breakroom. The room divider is present to keep residents from using this hallway as access to the patio because 15 white bi-fold doors are being stored in the hallway. However, the 3-panel room divider is not secured and can be tipped over with minimal effort which would cause a tripping hazard.

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.)

See Page 2A of 8

Legal Entity Representative

Theresa Ryhal

Signature

Theresa Ryhal Administrator
1-3-2020 Date

Printed Name and Title

Date

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The above plan of correction is approved as of 1/7/2020 (Date)

Plan of correction implementation status as of 1/7/2020 (Date)

Implemented

Not Implemented

The above plan of correction was approved by *ER* (Initials)

POL

2600

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

On 10/23/19 at approximately 10:15 a.m., there was a 5' high, 3-panel room divider blocking the approximately 20' long hallway that leads to the courtyard. This hallway connects to the main hallway near the employee breakroom.

The room divider is present to keep residents from using this hallway as access to the patio because 15 white bi-fold doors are being stored in the hallway. However, the 3-panel room divider is not secured and can be tipped over with minimal effort which would cause a tripping hazard.

10/23/2019 Doors were secured on date of inspection. Attachment 88.a #1

11/20/2019 Doors removed. Attachment 88.a #1

11/20/2019 Additional storage area has been acquired to house the bi-fold doors and other similar items if needed in the future.

10/24/2019 Maintenance Director educated by administrator to Regulation 88.a and to not put items that need secured in a common area and if a room divider is used, it would need to be secured.

Administrator and or designee will walk community daily to ensure all common areas area are free of hazard, clean and good working order.

Theresa Ryhal

Theresa Ryhal, Administrator 1/3/2020



1/7/2020

91 - Telephone Numbers

Regulations

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

On 10/23/19 at 11:00 a.m, there were none of the required emergency telephone numbers posted on or near the cordless phone setting on the bedside table in resident room #308.

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.)

See Page 3A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal ADMINISTRATOR 1-3-2020
Printed Name and Title Date

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(Date)

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(Date)

The above plan of correction was approved by

ER
(Initials)

- Implemented
- Not Implemented

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation:

On 10/23/19 at 11:00 a.m, there were none of the required emergency telephone numbers posted on or near the cordless phone setting on the bedside table in resident room #308.

10/23/2019 resident residing in room 308 was provided with an emergency phone numbers in a frame to put on the night stand. This framed picture will be used moving forward for any resident that does not want a sticker on their phone.

Attachment 91. #1

Audit of all resident rooms was conducted to ensure all residents had an Emergency Sticker or if they preferred a framed picture . Completed by 12/31/2019

Starting 10/24/19 All new move ins were given a paper at move in to indicate if they preferred a framed picture instead of a phone sticker.

Attachment 91. #2 and Attachment 91 #3(effective 1/2/2020)

Administrator will educate all staff on regulation 2600.91 and the 2 options of posting a sticker or framed picture with ER numbers by 1-30-20

Starting 1/1/2020 Administrator or designee will conduct weekly rounds for 3 months, then monthly and at move-in of community including resident's rooms to ensure emergency phone numbers are posted.

This will be part of the Quality Assurance monthly meeting.

Theresa Ryhal

Theresa Ryhal, ADMINISTRATOR

1-3-2020

[Signature] 1/7/2020

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drill completed on 6/26/19 at 1:10 does not include if the drill was conducted in the a.m. or p.m.

The fire drill record for the fire drill completed on 3/26/19 at 11:10 does not include if the drill was conducted in the a.m. or p.m.

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.)

See Page 4A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal, ADMINISTRATOR 1-3-2020
Printed Name and Title Date

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(Date)

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(Date)

Implemented

Not Implemented

The above plan of correction was approved by *CP*
(Initials)

POC

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.


Description of Violation

The fire drill record for the fire drill completed on 6/26/19 at 1:10 does not include if the drill was conducted in the a.m. or p.m. The fire drill record for the fire drill completed on 3/26/19 at 11:10 does not include if the drill was conducted in the a.m. or p.m.

On 10/30/2019, the Executive Director and Director of Maintenance reviewed regulation 2600.132(c) Attachment 132.c #1

Fire Drill Log will be reviewed at Monthly Safety meeting by safety committee attendees. Executive Director or Designee will initial on the log that it was reviewed for accuracy.

Theresa Ryhal THERESA Ryhal, ADMINISTRATOR 1-3-2020

 1/7/2020

184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed Humalog - 15 units 3 times a day. However, on 10/29/19 at 9:50 a.m., there was a vial of insulin in the medication cart with prescription label for resident #2 that indicates Humalog 75/25 vial 10ml 75/25 - Inject 20 units three times a day before meals.

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.)

See Page 5A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal, Administrator 1-3-2020
Printed Name and Title Date

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(Date)

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- Not Implemented

The above plan of correction was approved by *[Signature]*
(Initials)

POC

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

- 4. The prescribed dosage and instructions for administration

Description of Violation

Resident #2 is prescribed Humalog - 15 units 3 times a day. However, on 10/29/19 at 9:50 a.m., there was a vial of insulin in the medication cart with prescription label for resident #2 that indicates Humalog 75/25 vial 10ml 75/25 Inject 20 units three times a day before meals.

10/29/2019 Immediately Nurse confirmed correct dosage of resident #2. Attachment 184.a #6
A change of direction sticker applied to insulin.

11/1/2019 Community nurse conducted Cart audit of all medication carts in the building.
Attachment 184.a #4

11/12/2019 Pharmacy completed cart audit.
Attachment 184.a #3

11/4/2019 This regulation was reviewed with the nursing staff and Train the Trainer.

- Attachment 184.a #1
- Attachment 184.a #2

Nursing Staff will re-educate all medication technicians on prescription label and MAR match and Regulation 184.a by 1/31/2020

Nurse or designee will conduct monthly cart audits and pharmacy will conduct quarterly cart audits starting in January 2020 and results of the audits will be reviewed monthly at the Quality Assurance meeting.

Attachment 184.a #5 Page 3

Theresa Ryhal THERESA RYHAL ADMINISTRATOR 1-3-2020
 1/7/2020

185a - Implement Storage Procedures

Regulations

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 Violation

On 10/29/19 at 10:21 a.m., resident #3's glucometer was not calibrated to the current date and time. The most recent reading in the glucometer indicates "04-11 12:25am" which corresponds to the reading for 10/29/19 at 8:00 a.m. in the resident's October 2019 medication administration record (MAR).

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.)

See Page 6A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal ADMINISTRATOR 1-3-2020
Printed Name and Title Date

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(Date)

The above plan of correction was approved by *GR*
(Initials)

Implemented
 Not Implemented

POC

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 Violation

On 10/29/19 at 10:21 a.m., resident #3's glucometer was not calibrated to the current date and time. The most recent reading in the glucometer indicates "04-11 12:25am" which corresponds to the reading for 10/29/19 at 8:00 a.m. in the resident's October 2019 medication administration record (MAR).

10-29-2019 Resident #3 glucometer was corrected to accurate date and time. Batteries of resident #3 was recently changed , reason date was not accurate day of inspection.

10/30/2019 Physician was notified of glucometer not correct with date and time.

Attachment 185.a #7

10/30/2019 all current resident's glucometers were audited for correct date and time.

10/31/2019 thru 11/11/10/2019 All med techs were re-educated by nurse that all glucometers need checked daily on each shift for accurate date and time. And, to document in MAR the day batteries are changed. Additional training included changing the date and time for the most commonly used glucometer.

Attachment 185.1 #1 to #3 and #5 to #6

Ongoing: 1/1/2020 Glucometers will be checked and verified monthly for accuracy. This will be part of the monthly Quality Assurance meeting.

1/1/2020 Nurse or Designee will monitor glucometer daily for 3 months for accuracy, then weekly. Date, and time and results will be reviewed at monthly Quality Assurance meeting.

Theresa Ryhal Theresa Ryhal

ADMINISTRATOR 1-3-2020
1/7/2020

225c - Additional Assessment

Regulations

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

On 10/23/19, resident #5's annual assessment completed 12/7/18 was not updated to include that the resident is to have a bolster on each side of the bed to reduce the risk of the resident falling out of bed as indicated on the resident's hospice recertifications/Plans of Care dated 2/20/19 and 5/29/19

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.)

See Page 7A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal ADMINISTRATOR
Printed Name and Title

1-3-2020
Date

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(Date)

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(Date)

The above plan of correction was approved by *ER*
(Initials)

- Implemented
- Not Implemented

POC

2600.

225.c. The resident shall have additional assessments as follows:

Description of Violation

On 10/23/19, resident #5's annual assessment completed 12/7/18 was not updated to include that the resident is to have a bolster on each side of the bed to reduce the risk of the resident falling out of bed as indicated on the resident's hospice recertifications/Plans of Care dated 2/20/19 and 5/29/19

10/30/2019 Resident assessment updated to reflect bolsters.

Attachment 225.c #1 page 2

An audit of all current resident's assessments for accuracy will be completed by

10/31 2019 Nurses re-educated to this regulation

Attachment 225.c #2

Administrator or designee will monitor all new assessments for accuracy and will be reviewed at the monthly Quality Assurance meeting.

Theresa Ryhal

Theresa Ryhal

ADMINISTRATOR

1-3-2020



1/7/2020

233c - Key-Locking Devices

Regulations

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

On 10/23/19, at approximately 11:15 a.m., the directions for operation of the locked gate to exit the Secure Dementia Care Unit's outdoor patio were incorrect. The directions posted to the right of the large exit gate included a code that provided 3 numeric digits. However, the numeric code to release the gate consisted of 4 digits.

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.)

See Page 8A of 8

Legal Entity Representative

Theresa Ryhal
Signature

Theresa Ryhal ADMINISTRATOR 1-3-2020
Printed Name and Title Date

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(Date) (Date)

Implemented
 Not Implemented.

The above plan of correction was approved by *ER*
(Initials)

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

On 10/23/19, at approximately 11:15 a.m., the directions for operation of the locked gate to exit the Secure

Dementia Care Unit's outdoor patio were incorrect. The directions posted to the right of the large exit gate included a code that provided 3 numeric digits. However, the numeric code to release the gate consisted of 4 digits.

10/23/2019 The code was corrected and posted.

Attachment 233.c #2


11/1/2019 Administrator reviewed this regulation with: Maintenance Director, Nurses, Training Development Coordinator, Business Office Coordinator

Attachment 233.c #1

By 1/31/2020 Administrator will educate staff on need for correct code for Locking device posted and accurate.

Administrator and or designee will monitor all mag locked egresses to ensure directions/code posted, accurate and working properly.

Theresa Ryhal Theresa Ryhal ADMINISTRATOR 1-3-2020

 1/7/2020