pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail [Tanya.Mccormick@elmcroft.com]

MAILING DATE: April 15, 2020

Mr. Christian N. Cummings
President
EC OPCO Altoona LLC
Eclipse Senior Living
ATTN: LICENSING
5885 Meadows Road, Suite 500
Lake Oswego, Oregon 97035

RE: Elmcroft of Altoona
170 Red Fox Drive
Duncansville, Pennsylvania 16635
Certificate #: 333730

Dear Mr. Cummings:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Office of Long-term Living) review on January 8, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Gloria Emick

Gloria Emick
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *ELMCROFT OF ALTOONA* License Number: *33373*
Address: *170 RED FOX DRIVE,, DUNCANSVILLE, PA 16635*
County: *BLAIR* Region: *CENTRAL*

Administrator

Name: *Tanya McCormick* Phone: *8146958425* Email: *Tanya.mccormick@elmcroft.com*

Legal Entity

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

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *10/01/1997* Issued By: *Labor and industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *40* Waking Staff: *30*

Inspection

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

Inspection Dates and Department Representative

01/08/2020 - On-Site: Kellie Cargile, Cybil Bomberger

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *66* Residents Served: *34*

Secured Dementia Care Unit

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

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *34*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *6*
Have Physical Disability: *1*

Tanya M. McCormick 02/07/2020
ED

65a - FS Orientation 1st Day

Regulations

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.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.

Description of Violation

Staff Person A, hired 2/21/19, Staff Person B, hired 4/3/19, and Staff Person C, hired 6/13/29, did not receive orientation in general fire safety and emergency preparedness.

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. On 01/14/2020, Staff Members A, B & C received Fire Walk and Emergency Medical Procedure training. (Exhibits 1-6)
2. On 01/14/2020, staff members participated in a Fire Walk and Emergency Medical Procedures Training. (Exhibit 7) Fire Walk training was administered by Maintenance Director. Emergency Medical Procedures training was administered by Administrator.
3. An audit of all staff personnel files will be conducted by 02/15/2020 to ensure all staff have received the appropriate training.
4. On 02/04/2020, all Leadership Personnel received training by the Administrator regarding regulation 2600.65.a (Exhibit 8)
5. Moving forward, the Administrator or Designee will complete the Fire Walk and Emergency Medical Procedures Training with all new staff on the first day of training according to regulation 65.a.
6. Ongoing: Administrator or Designee will monitor to ensure ongoing compliance.

Legal Entity Representative

Signature — Printed Name and Title: TANYA A. MCCORMICK, EXECUTIVE DIRECTOR — Date: 02/07/2020

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The above plan of correction is approved as of 4/15/20 (Date)

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

Plan of correction implementation status as of 4/15/20 (Date)

XX Implemented

Not Implemented

65b - Rights/Abuse 40 Hours

Regulations

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
4. Reporting of reportable incidents and conditions.

Description of Violation

Staff Person B completed his/her 40th scheduled work hour on 4/9/19. However, this staff person did not complete training in reporting of reportable incidents and conditions until 4/19/19.

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.)

1. An audit of all staff personnel/training files will be completed by 02/15/2020 to verify that all staff received Reporting of Reportable Incidents and Conditions Training within the first 40 scheduled working hours.

2. On 02/04/2020, all Leadership Personnel received training regarding regulation 2600.65.b (Exhibit 8)

3. Moving forward, the Administrator or Designee will schedule all required courses to be completed during the first 40 scheduled working hours. The Administrator or Designee will review and sign the attestation of completion. (Exhibit 9)

4. Ongoing: Administrator or Designee will monitor and ensure ongoing compliance.

Legal Entity Representative

Signature | TANYA A. MCCORMICK, EXECUTIVE DIRECTOR (Printed Name and Title) | 02/07/2020 (Date)

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85a - Sanitary Conditions

Regulations

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 1/8/2020, the bath mat in the bathroom of Bedroom 208 was covered in brown and black mold/mildew.

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. On 01/08/2020 the bath mat in Bedroom 208 was replaced with a new bath mat.
2. On 01/14/2020, The Resident Services Director and Administrator trained staff on proper sanitary conditions.
3. On 02/04/2020, all Leadership Personnel received training regarding regulation 2600.85.a (Exhibit 8) Training was administered by the Administrator.
4. The Administrator or Designee will complete an inspection of all bedrooms to be conducted by EOB 02/07/2020 where all bath mats will be removed.
5. Moving forward bath mats will not be permitted in showers.
6. Ongoing: Administrator or Designee will monitor and ensure ongoing compliance.

Legal Entity Representative

Signature | Tanya A. McCormick, Executive Director (Printed Name and Title) | 02/07/2020 (Date)

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141a 1-10 Medical Evaluation Information

Regulations

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

Resident #1's medical evaluation, dated 10/4/19, does not include the resident's health status.

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 PCP was contacted to secure a new DME. New, completed DME was received on 02/04/2020. (Exhibit 10)
2. On 02/04/2020, all Leadership Personnel received training regarding regulation 2600.141.a (Exhibit 8)
3. An audit of all resident files will be completed by 02/14/2020 to verify completed DME's are on file.
4. Moving forward, the Resident Services Director or Designee will be responsible for requesting a DME for each new resident. The RSD or Designee will be responsible for reviewing each DME upon receipt for completion. The RSD or Designee will provide follow-up to PCP to obtain any missing information when necessary.
5. Ongoing: Administrator or Designee will monitor and ensure ongoing compliance.

Legal Entity Representative

Signature | Tanya A. McCormick, Executive Director (Printed Name and Title) | 02/07/2020 (Date)

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187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #1 did not receive the prescribed Pantoprazole 40mg at 6 am on 1/3/2020, due to the medication not being available in the home.

Resident #2 did not receive the prescribed Tamsulosin .4mg at 8 am on 1/5/20, 1/6/20 and 1/7/20, due to the medication not being available in the home.

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 PCP was contacted. Script was sent to pharmacy. Medications for Resident A & B were in the building on 01/08/2020.
2. A Medication Cart Audit was performed on 01/09/2020. (Exhibit 11)
3. On 02/04/2020, all Leadership Personnel received training regarding regulation 2600.187.d (Exhibit 8)
4. On 01/14/2020, Medication Technicians received training on Med Cart audits and the importance of identifying scripts about run out.
5. Moving forward, Medication Cart Audits will be performed:
   a. Resident Services Director or Designee (weekly)
   b. Pharmacy (quarterly); First Quarter audit scheduled for 02/28/2020.
6. Scripts about to run out within 7 days, RSD or Designee will contact PCP and Pharmacy to ensure residents have medications available to administer as prescribed.
7. Ongoing: Administrator or Designee will monitor and ensure ongoing compliance.

Legal Entity Representative

Signature: Tanya A. McCormick | Printed Name and Title: Tanya A. McCormick, Executive Director | Date: 02/07/2020

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