pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email to: elangardens@comcast.net
MAILING DATE: March 26, 2020

Ms. Mia Jacobs
Administrator
Elan Gardens Inc.
465 Venard Road
Clarks Summit, Pennsylvania 18411

RE: Elan Gardens
License #: 243750

Dear Ms. Jacobs:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on March 3, 2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

M. Moskalczyk

Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *ELAN GARDENS* **License Number:** *24375*
Address: *465 VENARD ROAD,, CLARKS SUMMIT, PA 18411*
County: *LACKAWANNA* **Region:** *NORTHEAST*

Administrator

Name: *Mia Jacobs* **Phone:** *5705854400* **Email:** *miacrotti@comcast.net*

Legal Entity

Name: *ELAN GARDENS INC*
Address: *465 VENARD ROAD, CLARKS SUMMIT, PA, 18411*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/18/1996* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *53* **Waking Staff:** *40*

Inspection

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

Inspection Dates and Department Representative

03/03/2020 - On-Site: Amy Deluca, Duane Valence, Pam Harris

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served:** *48*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *1* **Are 60 Years of Age or Older:** *47*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *5* **Have Physical Disability:** *0*

18 - Compliance With Laws

Regulations

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The battery-operated Carbon Monoxide Alarm located on the upper wall between the dairy and meat kitchens had an installed battery that did not contain a label with the date of installation. The alkaline battery manufacture's label indicated 2018.

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.)

The Maintenance Coordinator inadvertently did not change the batteries in the Carbon Monoxide detector, located on the upper wall between the dairy and meat kitchens. In all other locations of the facility hard-wired detectors were installed to replace battery operated units. This unit was not replaced, causing the deficiency. Upon discovery, in the presence of the DHS surveyor, the Maintenance Coordinator replaced the old batteries and labeled the unit "batteries replaced 3/3/20". All other Carbon Monoxide Detectors were audited and found to be hard-wired and in good operation. The Maintenance Coordinator/designee is responsible for testing detectors annually. The Administrator is ultimately responsible to ensure ongoing compliance.

Legal Entity Representative

Mia Jacobs
Signature

Mia Jacobs
Printed Name and Title

3/20/2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

[X] Implemented
[ ] Not Implemented

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

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff member A did not have training in the topics required under this regulation for the 2019 training year.

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.)

Staff Member A inadvertedly did not receive the required ancillary training topics during the 2019 year. The In-service Coordinator has been educated on the importance of ensuring all staff received necessary annual education. Staff Member A has since been in-serviced. The Administrator/designee will audit all in-service attendance sheets, monthly, to ensure all appropriate staff have received necessary in-service education. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. Ultimately the Administrator is responsible for ensuring ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Mia Jacobs	Mia Jacobs	3/20/20

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

- [X] Implemented
- [ ] Not Implemented

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

81b - Resident Personal Equipment

Regulations

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident # 1 in room 230 had an enabler assist bar attached to the bed with a large opening that was not covered which could be hazardous to the resident and could result in injury to resident #1.

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.)

Elan Gardens recognizes the importance of ensuring resident safety and preventing potential injury. Resident in room 230, bed enabler assist bar was overlooked by staff, and was not covered appropriately to prevent injury. Upon discovery, the assist bar was covered. There are no other enabler assist bars in the facility at this time. All enabler assist bars will be checked and documented weekly by the Wellness Coordinator/designee, to ensure they are properly covered. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. The Administrator is ultimately responsible for ensuring ongoing compliance.

Legal Entity Representative

Mia Jacobs
Signature

Mia Jacobs
Printed Name and Title

3/20/2020
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

[X] Implemented
[ ] Not Implemented

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

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

Resident bedroom 321 occupied by residents # 2 and # 3 has four landline telephones. Two were located in the sitting area and two other phones were located in the bedroom area. None of the four landline phones had the emergency telephone numbers required by this regulation posted on or near these phones.

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 important for residents to have necessary emergency contact numbers readily accessible, in the event of an emergency. The telephones in room 321 were overlooked, causing the absence of the emergency telephone numbers. Upon discovery, the telephone numbers were added to all phones in room 321. All other telephones were audited and found to be in compliance. The Assistant Administrator/designee will monitor telephones monthly to ensure that emergency numbers are present. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. The Administrator is ultimately responsible to ensure ongoing compliance.

Legal Entity Representative

Mia Jacobs	Mia Jacobs	3/20/2020
Signature	Printed Name and Title	Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

[X] Implemented
[ ] Not Implemented

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

124 - Notice to Fire Department

Regulations

2600.

124. The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The home's current notice to the fire department did not list the capacity of 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.)

The capacity was accidentally eliminated from the evacuation letter to the first department. A new letter was drafted and sent to the fire department, noting the home's capacity. The Administrator/designee will check the evacuation letters prior to sending. The Administrator is ultimately responsible for ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Mia Jacobs	Mia Jacobs	3/20/2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

- [X] Implemented
- [ ] Not Implemented

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

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:

Description of Violation

Resident #1 has an order for Tylenol to be taken 2 times per day at 2pm and 8pm. The label on the medication stated the order was 2 tablets, three times per day as needed. The pharmacy label did not match the current order for the medication.

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 important for MAR's to match pharmacy labels as to not cause potential medication errors. A new pharmacy label was not obtained when the Tylenol order was changed. Upon discovery, the pharmacy was contacted and a new pharmacy label was requested and obtained. All MARs and pharmacy labels were audited and found to to be in compliance. The Wellness Coordinator/designee will audit orders monthly to ensure MARs entries and pharmacy labels match. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. The Administrator is ultimately responsible for ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Mia Jacobs	Mia Jacobs	3/20/2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

- [X] Implemented
- [ ] Not Implemented

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

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

Resident #4 has an order for Mucinex to be administered as needed. The home did not have this medication on hand.

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.)

Resident #4's Mucinex was discarded upon expiration. The physician was contacted and the medication was requested to be discontinued, however an order was not obtained, nor was the PRN medication reordered. Upon discovery, the medication was again requested to be discontinued and an order was received. The Wellness Coordinator/designee will randomly audit PRN medications monthly to ensure medications are present. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. Ultimately the Administrator is responsible for ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Mia Jacobs	Mia Jacobs	3/20/2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

[X] Implemented
[ ] Not Implemented

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

187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
6. Dose.
8. Frequency of administration.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #4 has an order for Lipitor, 1 tablet daily. There was no diagnosis for this medication listed on the Medication administration record (MAR). Also, there was no diagnosis listed for the resident's PRN order for Mucinex.

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.)

The diagnosis for Resident #4's medications was inadvertently not documented. The diagnosis was added to the medications entries upon discovery. All other MAR entries were audited to be complete with diagnosis. The Wellness Coordinator/ designee will audit at random, monthly, MARs to ensure diagnosis are listed. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. Ultimately the Administrator will be responsible for ongoing compliance.

Legal Entity Representative

Signature	Printed Name and Title	Date
Mia Jacobs	Mia Jacobs	3/20/2020

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

[X] Implemented
[ ] Not Implemented

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

224a - Preadmission Screen Form

Regulations

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident # 1's preadmission screening dated 2/12/18 was incomplete. Section II-1 " ability to self-administer medications" was left blank.

Resident #5's preadmission screening dated 9/3/2019 part III was incomplete. There was no determination noted "yes or no" that resident #5's needs could be met in a Personal Care 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.)

The identified sections of the preadmission screens were accidentally left blank. The remaining current preadmission screens were audited and found to be in compliance. The Assistant Administrator/designee will audit all new preadmission screens to ensure completion. Audits will be reviewed at quarterly quality management meetings to determine the need to continue. Ultimately the Administrator will be responsible for ongoing compliance.

Legal Entity Representative

Mia Jacobs	Mia Jacobs	3/20/2020
Signature	Printed Name and Title	Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 3-24-2020 (Date)

Plan of correction implementation status as of 3-24-2020 (Date)

- [x] Implemented
- [ ] Not Implemented

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