

Department of Human Services
Bureau of Human Service Licensing

July 9, 2021

██████████ VICE PRESIDENT/TREASURER
EC OPCO CHIPPEWA LLC
5885 MEADOWS ROAD, SUITE 500
ECLIPSE SR LIV ATTN LICENSING
LAKE OSWEGO, OR 97035

RE: ELMCROFT OF CHIPPEWA
104 PAPPAN BUSINESS DRIVE
BEAVER FALLS, PA, 15010
LICENSE/COC#: 44901

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 05/06/2021, 05/07/2021, 05/24/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC**

Facility Information

Name: ELMCROFT OF CHIPPEWA **Licen e #:** 44901 **Licen e Expiration Date:** 01/18/2022
Addr e : 104 PAPPAN BUSINESS DRIVE, BEAVER FALLS, PA 15010
County: BEAVER **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** 7248913333 **Email:** [REDACTED]

Legal Entity

Name: EC OPCO CHIPPEWA LLC
Address: 5885 MEADOWS ROAD, SUITE 500, ECLIPSE SR LIV ATTN LICENSING, LAKE OSWEGO, OR, 97035
Phone: 7248913333 **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 05/22/1999 **Issued By:** Labor & Industry
Type: I-1 **Date:** 03/18/2011 **Issued By:** Chippewa Township

Staffing Hours

Re ident Support Staff: 0 **Total Daily Staff:** 58 **Waking Staff:** 44

Inspection

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 05/24/2021

Inspection Dates and Department Representative

05/06/2021 - On-Site: [REDACTED]
05/07/2021 - Off-Site: [REDACTED]
05/24/2021 Off Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 85 **Residents Served:** 44

Secured Dementia Care Unit

In Home: Yes **Area:** Memory Care **Capacity:** 20 **Re ident Served:** 9

Hospice

Current Residents: 5

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 44
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 14 **Have Physical Disability:** 0

Inspections / Reviews

05/06/2021 - Partial

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow-Up Date: *07/05/2021*

7/2/2021 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/12/2021*

7/9/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *08/01/2021*

16c - Written Incident Report

1. Requirements

2600.

- 16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Resident #1's initial assessment and support plan, dated [REDACTED], indicates [REDACTED] is not independent in bathing and direct care staff will provide assistance. On [REDACTED] at approximately 6:15 AM, resident #1 awoke, got dressed and ready for breakfast. Staff person B entered [REDACTED] room and informed [REDACTED] needed to take a shower. Resident #1 told staff person B [REDACTED] was already dressed and ready for breakfast and [REDACTED] could get [REDACTED] shower after breakfast. Staff person B insisted [REDACTED] take [REDACTED] shower, proceeded to turn on the shower water and provided the resident with a washcloth and towel. Resident #1 undressed and got into the shower. Staff person B left the room, stating [REDACTED] would be right back. Resident #1 finished showering, turned off the water, and when exiting the shower, slipped and fell on the bathroom floor. Resident #1 was unable to stand and dragged [REDACTED] across [REDACTED] bathroom floor to a chair in [REDACTED] bedroom, where staff person B found the resident when [REDACTED] returned to the room. Resident #1 was transported via ambulance to the emergency room (ER), where [REDACTED] reported to ER staff [REDACTED] got out of the shower without any help and fell directly onto [REDACTED] left knee and was able to drag [REDACTED] to the chair and push [REDACTED] up. Resident #1 was diagnosed with a left displaced and depressed tibial plateau fracture and large lipohearthrosis, [REDACTED] was admitted to the hospital, had surgery, and was discharged to a skilled nursing facility [REDACTED].

On 4/14/21, resident #1's POA reported to staff person A, the home's administrator, that resident #1 stated no staff were present in [REDACTED] room on [REDACTED] when [REDACTED] fell while exiting the shower, sustaining a serious injury. However, the home did not report this allegation to the Department until 5/8/21.

Plan of Correction

Accept

A state reportable was submitted by Administrator on 5.8.2021 for allegations of abuse/neglect that occurred on 4.14.2021.

The Administrator reported allegation of abuse/neglect to OAPS on 5.8.2021 that occurred on 4.14.2021.

Administrator will conduct a training with all current managers on 16c Written incident reports and Act 13 OAPS reporting by July the 9th 2021.

A new Administrator will be starting July the 12th 2021 [REDACTED] will receive training on 16c Written incident reports as well as Act 13 reporting within [REDACTED] first 40 hours of work and annually as well.

Administrator or designee will continue to monitor for compliance of 16c reportable incidents and conditions along with Act 13 OAPS reporting as well.

Completion Date: 07/31/2021

42b - Abuse

1. Requirements

2600.

- 42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

42b - Abuse (continued)

Description of Violation

Resident #1's initial assessment and support plan, dated [REDACTED], indicates [REDACTED] is not independent in bathing and direct care staff will provide assistance. On [REDACTED] at approximately 6:15 AM, resident #1 awoke, got dressed and ready for breakfast. Staff person B entered [REDACTED] room and informed [REDACTED] needed to take a shower. Resident #1 told staff person B [REDACTED] was already dressed and ready for breakfast and [REDACTED] could get [REDACTED] shower after breakfast. Staff person B insisted [REDACTED] take [REDACTED] shower, proceeded to turn on the shower water and provided the resident with a washcloth and towel. Resident #1 undressed and got into the shower. Staff person B left the room, stating [REDACTED] would be right back. Resident #1 finished showering, turned off the water, and when exiting the shower, slipped and fell on the bathroom floor. Resident #1 was unable to stand and dragged [REDACTED] across [REDACTED] bathroom floor to a chair in [REDACTED] bedroom, where staff person B found the resident when [REDACTED] returned to the room. Resident #1 was transported via ambulance to the emergency room (ER), where [REDACTED] reported to ER staff [REDACTED] got out of the shower without any help and fell directly onto [REDACTED] left knee and was able to drag [REDACTED] to the chair and push [REDACTED] up. Resident #1 was diagnosed with a left displaced and depressed tibial plateau fracture and large lipohemarthrosis, [REDACTED] was admitted to the hospital, had surgery, and was discharged to a skilled nursing facility [REDACTED].

Plan of Correction

Accept

Administrator suspended employee pending investigation on 5.8.2021 for incident that occurred on 4.14.2021.

Administrator will terminate employee 7.6.2021.

Administrator set up training for all current staff with APS, [REDACTED] via Zoom on Abuse/Neglect 6.2.2021.

Administrator or designee will retrain all staff during staff meetings by the end of July on 42b Abuse/Neglect.

Administrator or designee will re-educate staff regarding providing direct care services as indicated on the RASP (Support plan) including bathing/showering.

Administrator will continue to interview five residents each week for two more months until 8.15.2021 to assess for any concerns regarding care, treatment, or neglect.

Administrator or designee will review interviews during quality meeting for July and August.

A binder with education material on abuse/neglect will be placed in a conspicuous place for staff to reference by the end of July.

Completion Date: 07/31/2021