

Department of Human Services
Bureau of Human Service Licensing

August 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 07/19/2021 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:** L&I
Type: I-2 **Date:** 03/18/2011 **Issued By:** Chippewa Township

Staffing Hours

Re ident Support Staff: 0 **Total Daily Staff:** 73 **Waking Staff:** 55

Inspection

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 07/19/2021

Inspection Dates and Department Representative

07/19/2021 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 85 **Residents Served:** 47

Secured Dementia Care Unit

In Home: Yes **Area:** Memory Care **Capacity:** 20 **Residents Served:** 17

Hospice

Current Residents: NA

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 47
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 26 **Have Physical Disability:** 0

Inspections / Reviews

07/19/2021 - Partial

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow-Up Date: *08/09/2021*

8/9/2021 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *09/01/2021*

57d - Waking Hours

1. Requirements

2600.

57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 7/4/2021, the home served 45 residents, including 26 residents with mobility needs. Accordingly, the home was required to provide a minimum of 53.25 hours of direct care services during waking hours; however, only 49.32 hours of direct care services were provided during waking hours.

Plan of Correction

Accept

Action: the schedule was reviewed on 7-19-2021 and open shifts were filled for that week to confirm that 75% of personal care service hours are available during waking hours.

Training: The Operations Specialist re-educated community leadership team on 8-5-2021 regarding regulation 57d which included direct care staffing to encompass at least 75% of personal care hours during waking hours; direct care staff persons to be available at least 1 hour per day of personal care services to each mobile resident; and direct care staff to be available at least 2 hours per day of personal care services to each resident that has mobility issues.

Ongoing- Executive Director and/or designee will review staffing schedule daily to verify community is staffed to provide 75% of personal care hours during waking hours. Monitoring will be reviewed during weekly Quality Care Review (QCR) meeting with nurse(s), Executive Director, and other Leadership managers as available.

Completion Date: 08/31/2021

60a - Staff/Support Plan

1. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Repeat Violation

On 7/10/21, the home served 44 residents, 25 of which had mobility needs, including at least 5 requiring the assistance of 2 staff persons to evacuate in an emergency. The home's staffing schedule indicates between 11:00p.m. and 7:00a.m. there were only 2 staff members present in the home which was not enough to provide personal care services, supervision and safe evacuation of residents in the event of an emergency as specified on the resident's assessments and support plans.

On 7/16/21, the home served 46 residents, 25 of which had mobility needs, including at least 5 requiring the assistance of 2 staff persons to evacuate in an emergency. The home's staffing schedule indicates between 11:00p.m. and 7:00a.m. there were only 2 staff members present in the home which was not enough to provide personal care services, supervision and safe evacuation of residents in the event of an emergency as specified on the resident's assessments and support plans.

Repeat Violation: 08/06/2020 et al

60a - Staff/Support Plan (continued)

Plan of Correction**Accept**

Action- The schedule was reviewed on 7-19-2021 by Executive Director and Nurse, and open 11-7am shifts were filled for the week. When the new weeks' schedules were created, 3 staff were scheduled on 11-7am shift based on review of the residents' assessments regarding mobility issues.

Training- During the QCR on 8-4-2021, the Executive Director and the Operations Specialist re-educated and reviewed with the Nurse regulation 60a with regards to modifying the staffing as appropriate to meet the needs of residents as noted in residents' assessments and support plan, with an emphasis on mobility needs. The Leadership team was re-educated on regulation 60a as well on 8-5-2021 with regards to mobility/immobility definitions; the use of assessments to obtain the information in regard to care needs as well as staffing appropriately to those needs by the Operations Specialist.

Ongoing- Executive Director and/or designee will review staffing schedule daily to validate that direct care staffing for residents meets the needs of the residents as specified in the residents' assessments and support plan, including mobility needs. Monitoring will be reviewed during weekly QCR meeting with nurse(s), Executive Director, and other Leadership managers as available. Any discrepancies identified will be addressed as appropriate

Completion Date: 08/31/2021

226a - Mobility Assessment

1. Requirements

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

The assessment for resident #1, dated 5/12/2021, indicates that the resident has only minimal mobility needs; however, staff and resident interviews, as well as observation by an agent of the Department, indicate that resident #1 requires the assistance of 2 staff persons for transferring.

Plan of Correction**Accept**

Action: Resident #1's assessment was updated on 8-5-2021 to indicate that ■■■ is a 2-person transfer. Per direct observation, resident can transfer on ■■■ own without staff assistance, but there are days ■■■ may require more assistance. PT/OT services through Hospice were ordered on 8-5-2021 for resident #1. By 8-31-2021 all current residents' assessments and support plans will be reviewed to verify all information is accurate.

Training: During the QCR on 8-4-2021, the Executive Director and the Operations Specialist re-educated and reviewed with the Nurse regulation 226a; importance of review of assessment of residents with emphasis on mobility needs; and that assessments and support plans need to be reviewed to confirm appropriate staffing.

On 8-18-2021, The Executive Director and the Nurse will re-educate direct care staff and nurses on proper documentation of care within the community's electronic health record tool used by nurse(s)/designees when completing a residents assessment.

Ongoing: By 8-30-2021, during QCR weekly meeting the assessments and support plans of all current residents will be reviewed by Executive Director and Nurse to verify mobility needs of residents and confirm staffing per residents needs. Thereafter; mobility needs will be evaluated weekly at QCR by nurse, Executive Director, and the group will update Support plans as needed. At time of assessments, we will discuss with direct care staff to verify information is correct.

Completion Date: 08/31/2021

233c - Key-Locking Devices

1. Requirements

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 Repeat Violation

The directions for operating the magnetic lock releases on the SDCU exits near bedrooms [REDACTED] and [REDACTED] were incomplete. Both codes require entry of a numerical sequence followed by the "star" key; however, the directions posted at these exits did not include any indication of the inclusion of the "star" key in the sequence.

Repeat Violation: 10/23/2019 et al

Plan of Correction

Accept

Action: on 7-20-2021 Directions for the door code were changed to include a star at the end of the access sequence.

All doors in Memory Care were audited by the Executive Director to ensure proper code displayed.

Training: on 8-5-2021, the Operations Specialist re-educated the Maintenance Director on the requirements that the entire code (including symbols, if applicable) needs to be on the directions to get in and out of the SDU exits. All community Leadership will be trained on 8-5-2021 by the Operations Specialist regarding the abovementioned requirements.

Ongoing: The Maintenance Director and/or designee will perform daily checks to verify the posted codes are correct at all SDU entrances and exits.

Completion Date: 08/31/2021