

Department of Human Services
Bureau of Human Service Licensing

August 19, 2022

[REDACTED], NHA
[REDACTED]
[REDACTED]

RE: SILVER CREEK TERRACE
791 JOHNSONBURG ROAD
ST. MARYS, PA, 15857
LICENSE/COC#: 42602

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/01/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[REDACTED]

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: *SILVER CREEK TERRACE* License #: *42602* License Expiration: *06/20/2023*
Address: [REDACTED]
County: *ELK* Region: *WESTERN*

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: *ELK HAVEN NURSING HOME ASSOCIATION INC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *03/19/1997* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *47* Waking Staff: *35*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *04/01/2022*

Inspection Dates and Department Representative

04/01/2022 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* Residents Served: *47*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *4* Are 60 Years of Age or Older: *47*
Diagnosed with Mental Illness: *4* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *0* Have Physical Disability: *1*

Inspections / Reviews

04/01/2022 - Full

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *05/01/2022*

06/21/2022 - POC Submission

Inspections / Reviews (*continued*)

Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/26/2022*

06/24/2022 - POC Submission

Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/01/2022*

08/19/2022 - Document Submission

Reviewer: [REDACTED] Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

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 Influenza Awareness Act, effective July 2016, states that "Each facility shall ensure that the required influenza information is posted in a public place in the facility year-round." However, the home does not have a copy of the required influenza awareness poster posted in a public place.

Plan of Correction

Accept

- 1) Administrator made contact to obtain poster from OHS during the time of inspection.
- 2) Poster obtained and has been displayed per regulation in the main lobby for residents, staff and visitors to observe.
- 3) A monthly observation/audit will be completed by the administrator or designee to ensure that the poster is intact and remains on display in the lobby
- 4) After a period of one year, administrator/designee will audit/observe post every three months for the following year to ensure compliance is maintained.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) Administrator made contact to obtain poster from OHS during the time of inspection.
- 2) Poster obtained and has been displayed per regulation in the main lobby for residents, staff and visitors to observe.
- 3) A monthly observation/audit will be completed by the administrator or designee to ensure that the poster is intact and remains on display in the lobby
- 4) After a period of one year, administrator/designee will audit/observe post every three months for the following year to ensure compliance is maintained.

26b - Quality Management Plan Content

1. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review dated 3/29/22 did not address reportable incidents and conditions, complaint procedures and staff person training.

Plan of Correction

Accept

- 1)The quality management review dated 3/29/2022 did address reportable incidents and conditions as well as staff person trainings.

26b - Quality Management Plan Content (continued)

- 2) Administrator immediately adjusted the format of the quality management plan to ensure clarity and efficiency.
- 3) Administrator to use new format for all quality management meetings in the future.
- 4) Administrator will review in April 2022 QA meeting the new format with members.
- 5) Quality management plan to be reviewed annually and as needed by the administrator to maintain compliance.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) The quality management review dated 3/29/2022 did address reportable incidents and conditions as well as staff person trainings.
- 2) Administrator immediately adjusted the format of the quality management plan to ensure clarity and efficiency.
- 3) Administrator to use new format for all quality management meetings in the future.
- 4) Administrator will review in April 2022 QA meeting the new format with members.
- 5) Quality management plan to be reviewed annually and as needed by the administrator to maintain compliance.

65d - Initial Direct Care Training

1. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

- 2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff person A, hired on [redacted] began providing unsupervised ADL services on [redacted]. However, the staff person did not complete and pass the Department-approved direct care training course and pass the competency test.

Plan of Correction

Accept

- 1) Direct care staff member was immediately removed from performing direct care at the time of the survey.
- 2) Direct care staff member completed non-direct care tasks until completion of department approved training.
- 3) Direct care staff member completed the department approved training on 4/12/2022.
- 4) An audit completed 4/4/2022 by administrator to ensure that all direct care staff members were in compliance with regulation.
- 5) Administrator updated new hire check list to include completion of direct care training.
- 6) Administrator or designee to audit new hire records to ensure compliance with regulation for a time period not to exceed 2 years.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) Direct care staff member was immediately removed from performing direct care at the time of the survey.
- 2) Direct care staff member completed non-direct care tasks until completion of department approved training.
- 3) Direct care staff member completed the department approved training on 4/12/2022.
- 4) An audit completed 4/4/2022 by administrator to ensure that all direct care staff members were in compliance with regulation.

65d - Initial Direct Care Training (continued)

- 5) Administrator updated new hire check list to include completion of direct care training.
- 6) Administrator or designee to audit new hire records to ensure compliance with regulation for a time period not to exceed 2 years.

85e - Trash Outside Home

1. Requirements

2600.
 85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

The left front portion of the lid of the partially filled dumpster was open.

Plan of Correction

Accept

- 1)Trash lid was closed at the time of the findings by maintenance.
- 2)On 4/4/2022 Administrator ordered Magnetic signage for the dumpster stating to ensure all lids are closed when not in use.
- 3)On 4/4/2022 Staff was educated on importance of trash lids remaining closed.
- 4)Ongoing audits to be completed by environmental services weekly for a time period of six months ending September 2022.
- 5)After Six months, audit will be completed by environmental services on a monthly biases for an additional six months ending March 2023.
- 6)Environmental Services staff will inform administrator of any non compliance with the regulation.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1)Trash lid was closed at the time of the findings by maintenance.
- 2)On 4/4/2022 Administrator ordered Magnetic signage for the dumpster stating to ensure all lids are closed when not in use.
- 3)On 4/4/2022 Staff was educated on importance of trash lids remaining closed.
- 4)Ongoing audits to be completed by environmental services weekly for a time period of six months ending September 2022.
- 5)After Six months, audit will be completed by environmental services on a monthly biases for an additional six months ending March 2023.
- 6)Environmental Services staff will inform administrator of any non compliance with the regulation.

91 - Telephone Numbers

1. Requirements

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

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in the mechanical room.

Plan of Correction

Accept

- 1)Corrected at the time of the inspection by administrator.

91 - Telephone Numbers (continued)

- 2) Audit of facility completed on 4/4/2022 by administrator and environmental services to ensure that all outgoing lines within the facility have the appropriate emergency numbers posted.
- 3) Administrator provided education on 4/25/2022 to all staff regarding emergency phone numbers.
- 3) Ongoing random weekly audits by administrator or designee to ensure compliance with regulation for a period of six months.
- 4) After six months, audits will then be monthly for six months to ensure compliance.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) Corrected at the time of the inspection by administrator.
- 2) Audit of facility completed on 4/4/2022 by administrator and environmental services to ensure that all outgoing lines within the facility have the appropriate emergency numbers posted.
- 3) Administrator provided education on 4/25/2022 to all staff regarding emergency phone numbers.
- 3) Ongoing random weekly audits by administrator or designee to ensure compliance with regulation for a period of six months.
- 4) After six months, audits will then be monthly for six months to ensure compliance.

132d - Evacuation

1. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The fire safety expert's letter, dated 10/6/21, indicates a safe evacuation time of 7 minutes, 0 seconds. However, the fire drill on 12/14/21 at 10:50 pm., took 10 minutes, 32 seconds to complete.

Plan of Correction

Accept

- 1) On 4/25/2022 Staff education on fire drills completed with staff by administrator.
- 2) Unannounced sleeping fire drills will be completed with the average overnight staff of three.
- 3) Additional sleeping hours fire drill to be held within the 2022 year.
- 4) Next overnight drill scheduled for June 2022
- 5) Ongoing observations of staff to be completed during drills by administrator/designee, staff huddles to be completed after to discuss findings and improvements if any.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) On 4/25/2022 Staff education on fire drills completed with staff by administrator.
- 2) Unannounced sleeping fire drills will be completed with the average overnight staff of three.
- 3) Additional sleeping hours fire drill to be held within the 2022 year.
- 4) Next overnight drill scheduled for June 2022
- 5) Ongoing observations of staff to be completed during drills by administrator/designee, staff huddles to be completed after to discuss findings and improvements if any.

181d - Storing Medication

1. Requirements

2600.

181.d. If the resident does not need assistance with medication, medication may be stored in a resident's room for self-administration. Medications stored in the resident's room shall be kept locked in a safe and secure location to protect against contamination, spillage and theft.

Description of Violation

Resident #1 self-administers medications and stores medications in his/her room. On 4/1/22, at 11:55 am., the medication, [REDACTED] was unlocked, unattended in the resident's bedroom in the refrigerator.

Plan of Correction

Accept

- 1)Residents prescribed eye medication was removed from the residents room at the time of incident as the resident was not present in the room and room was unsecured.
- 2)Resident was educated on 4/1/2022 about the importance of securing room when their are medications present as well as educated on the regulations regarding storing medications in her room.
- 3)Education was completed with staff on 4/25/2022 regarding the regulation and compliance.
- 4)Assessment completed by administrator on 4/4/2022 to ensure resident could continue to safety self administer eye drops.
- 5)Random weekly audits to be completed by administrator/designee to ensure that when resident is out of her room, that her door is locked and the room is secured for six months.
- 6)After six months, audits to continue monthly for an additional six months.
- 7)If founded that room is unsecured, medication will be removed by staff and resident will be unable to continue to self store prescribed medications.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1)Residents prescribed eye medication was removed from the residents room at the time of incident as the resident was not present in the room and room was unsecured.
- 2)Resident was educated on 4/1/2022 about the importance of securing room when their are medications present as well as educated on the regulations regarding storing medications in her room.
- 3)Education was completed with staff on 4/25/2022 regarding the regulation and compliance.
- 4)Assessment completed by administrator on 4/4/2022 to ensure resident could continue to safety self administer eye drops.
- 5)Random weekly audits to be completed by administrator/designee to ensure that when resident is out of her room, that her door is locked and the room is secured for six months.
- 6)After six months, audits to continue monthly for an additional six months.
- 7)If founded that room is unsecured, medication will be removed by staff and resident will be unable to continue to self store prescribed medications.

183e - Storing Medications

1. Requirements

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

Description of Violation

Resident #2 is prescribed the medication, [REDACTED], 1 drop into affected eyes three times a day as needed. On 4/1/22, the medication, opened 7/12/21, was in the medication cart. According to the manufacturer's instructions the medication is to be disposed of 90 days after opening.

183e - Storing Medications (continued)

Plan of Correction

Accept

- 1) Medication removed from the cart and the time of the incident by administrator.
- 2) New bottle of prescribed eye drops ordered and obtained from the pharmacy at the time of survey.
- 3) Administrator provided Education 4/25/2022 with the staff regarding expiration dates of opened eye drops.
- 4) On 4/4/2022 Wellness coord checked all eye drops within the facility to ensure compliance with expiration dates.
- 5) Weekly random audit to be completed by wellness coordinator to ensure eye drops are not expired for a time period of six months.
- 6) After the initial six months, monthly random audits to ensure compliance with expiration dates for an additional six months.

Completion Date: 06/23/2022

Document Submission

Implemented

- 1) Medication removed from the cart and the time of the incident by administrator.
- 2) New bottle of prescribed eye drops ordered and obtained from the pharmacy at the time of survey.
- 3) Administrator provided Education 4/25/2022 with the staff regarding expiration dates of opened eye drops.
- 4) On 4/4/2022 Wellness coord checked all eye drops within the facility to ensure compliance with expiration dates.
- 5) Weekly random audit to be completed by wellness coordinator to ensure eye drops are not expired for a time period of six months.
- 6) After the initial six months, monthly random audits to ensure compliance with expiration dates for an additional six months.