

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

March 13, 2023

[REDACTED]
ECUMENICAL COMMUNITIES INC
[REDACTED]

RE: ECUMENICAL COMMUNITY OF
HARRISBURG
624 WILHELM ROAD
HARRISBURG, PA, 17111
LICENSE/COC#: 35361

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/24/2023, 01/25/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *ECUMENICAL COMMUNITY OF HARRISBURG* License #: *35361* License Expiration: *08/15/2023*
 Address: *624 WILHELM ROAD, HARRISBURG, PA 17111*
 County: *DAUPHIN* Region: *CENTRAL*

Administrator

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

Legal Entity

Name: *ECUMENICAL COMMUNITIES INC*
 Address: *830 CHERRY DRIVE, HERSHEY, PA, 17033*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *01/11/1994* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *90* Waking Staff: *68*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal* Exit Conference Date: *01/25/2023*

Inspection Dates and Department Representative

01/24/2023 - On-Site: [REDACTED]
 01/25/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *88* Residents Served: *65*

Secured Dementia Care Unit
 In Home: *Yes* Area: *Connections 1* Capacity: *18* Residents Served: *14*

Hospice
 Current Residents: *5*

Number of Residents Who:
 Receive Supplemental Security Income: *3* Are 60 Years of Age or Older: *65*
 Diagnosed with Mental Illness: *2* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

01/24/2023 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *02/13/2023*

02/24/2023 - POC Submission
 Submitted By: [REDACTED] Date Submitted: *03/09/2023*
 Reviewer: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/10/2023*

Inspections / Reviews (*continued*)

03/03/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/09/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/10/2023

03/13/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/09/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

- 3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 1/24/23 the home's last renewal inspection, completed 5/26 and 5/27/21, was not posted in a conspicuous and public place in the home.

Plan of Correction

Accept (JM - 03/03/2023)

- The last inspection report dated 5/26/21 and 5/27/21 were reposted immediately at the time of inspection by the campus ED on 1/24/23*
- The building ED beginning on 1/24/23 will ensure that the latest inspection report is posted at all times moving forward. The building ED will conduct weekly audits of the latest inspection reports and summaries to ensure that it is posted and available*

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/10/2023)

63a - First Aid/CPR Training

2. Requirements

2600.

- 63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

- On 1/12/23 from 11:00 PM to 7:00 AM. there were 60 residents in the home. During this time, one staff person was present with current certification in first aid and CPR.*
- On 1/13/23, from 11:00 PM to 7:00 AM, there were 60 residents in the home. During this time, no staff person working in the home had a current certification in first aid and CPR.*
- On 1/14/23, from 11:00 PM to 7:00 AM, there were 60 residents in the home. During this time, no staff person working in the home had a current certification in first aid and CPR.*

Plan of Correction

Accept (JM - 03/03/2023)

- The Talent Development Coordinator will track weekly and schedule additional trainings on CPR and First Aid beginning on 2/6/23. Classes has already been completed on 2/3/23, 2/9/23, 2/21/23, 2/24/23. More classes will be scheduled as needed. New CPR instructor trained on 2/27/23 at [REDACTED] for ongoing compliance with the regulation*
- The building manager or designee will ensure that sufficient trained staff are on each shift for each building to maintain compliance with the regulation. The building manager will check schedules daily to check for compliance starting on 2/6/23*
- The Director of Nursing or designee will check schedules weekly beginning on 2/6/23 or more often to ensure compliance with this regulation.*

Licensee's Proposed Overall Completion Date: 03/01/2023

63a - First Aid/CPR Training (*continued*)*Implemented (JM - 03/10/2023)*

82c - Locking Poisonous Materials

3. Requirements

2600.

82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

A container of Clorox Health Care Wipes, with a manufacturer's label indicating to contact a poison control center if ingested, was unlocked, unattended, and accessible to residents in the television cabinet in the Connections 1 secure dementia care unit (SDCU). The residents in Connections 1 have not been assessed to be capable of recognizing and using poisons safely.

Plan of Correction*Accept (JM - 03/03/2023)*

- The Clorox wipes were immediately removed at the time of inspection on 1/24/23*
- All Poisonous materials will be locked at all times starting on the day of inspection on 1/24/23*
- The unit manager or designee will perform spot checks 3 times a day to ensure compliance going forward to begin on 2/13/23. Spot checks will be documented daily for two weeks to establish a pattern. Documentation to be provided.*
- The unit manager will ensure compliance going forward*
- All staff were re-educated by the unit manager on the importance of locking poisonous materials on 2/6/23*

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/13/2023)

85e - Trash Outside Home

4. 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

At 10:20 AM the dumpsters for the recycling and trash were partially full and the sliding side doors were open. The dumpsters were not actively being used.

Plan of Correction*Accept (JM - 03/03/2023)*

- The dumpster lid was closed immediately at the time of inspection on 1/25/23 by the unit manager*
- Signs were again posted at the dumpster on 1/25/23 by the maintenance director to remind coworkers to keep the lid closed at all times*
- Maintenance Director or designee will ensure ongoing compliance with regular spot checks daily starting on 1/25/23*
- Staff was re-educated on 2/6/23 by the unit manager on the importance of keeping the outside trash lids closed at all times*

Licensee's Proposed Overall Completion Date: 03/01/2023

85e - Trash Outside Home (continued)

Implemented (JM - 03/10/2023)

89b - Hot Water Temperature

5. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 1/24/23 at 10:30 AM, the hot water temperature at the bathroom sink in bedroom 22 in Connections 1 measured 123.4 degrees Fahrenheit.

Plan of Correction

Accept (JM - 02/24/2023)

- The water temperature was corrected by turning down the temperature at the source on day of inspection 1/25/23
- The Director of Maintenance will continue normal monthly water temp checks and log that information monthly by checking 2 rooms per hallway.
- Any deviations of temperature where the water is too hot will be immediately corrected.
- Maintenance Director will ensure compliance going forward.

Licensee's Proposed Overall Completion Date: 02/13/2023

Implemented (JM - 03/10/2023)

91 - Telephone Numbers

6. 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 were no emergency telephone numbers to include the nearest hospital and fire department on or near Resident 3's telephones in bedroom.

Plan of Correction

Accept (JM - 03/03/2023)

- The emergency phone numbers had been removed by the resident
- The emergency phone numbers on a card were zip tied again to resident 3's phone in room by unit manager on 1/25/23
- The unit manager or designee will check all residents phones monthly starting on 2/1/23 to ensure ongoing compliance

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/13/2023)

121a - Unobstructed Egress

7. Requirements

2600.

121a - Unobstructed Egress (continued)

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 1/24/23 at 10:00 AM, four dining room chairs on the outside patio blocked egress from the home's dining room.

Plan of Correction

Accept (JM - 03/03/2023)

- *Three unused dining chairs had been placed in front of an exit door onto the patio in error*
- *The chairs were removed immediately at the time of the inspection on 1/24/23*
- *Staff was re-educated by the unit manager on 2/6/23 on not blocking the exits. Documentation available*
- *The unit manager or designee will complete daily spots checks through the building which include hallways and checking exit doors to make sure they are not obstructed. These daily checks started on 1/26/23 by the unit manager or designee and will be documented and reviewed by ED weekly*
- *The campus ED will be responsible for implementing and maintaining an acceptable plan of correction ongoing*

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/13/2023)

132e - Fire Drill Sleeping Hours**8. Requirements**

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 7/28/22 at 6:27 AM. The previous sleeping hours fire drill was conducted on 12/30/21 at 6:09 AM.

Plan of Correction

Accept (JM - 03/03/2023)

- *The fire drill was held during sleeping hours however it was not done within the 6 month time frame.*
- *A fire drill during sleeping hours was conducted on 1/28/23 and will continue 6 months from the last date of drill*
- *A tickler system created by the campus ED via Outlook calendar was implemented on 1/30/23 to keep track of the sleeping hour fire drills for the maintenance director and Campus ED to ensure that the next sleeping hour fire drill will be in compliance.*

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/10/2023)

183e - Storing Medications**9. 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

The north hallway medication cart contained a loose blue and white tablet marked "600."

183e - Storing Medications (continued)

Plan of Correction

Accept (JM - 02/24/2023)

- The medication was removed from the cart and destroyed of properly on 1/24/23 by the ADON.
- The importance of proper storage of medications was discussed with pertinent staff on 2/8/23 by the Director of Nursing. Training documentation to be provided.
- The DON and ADON will monitor each med cart for proper storage of medications starting on 2/8/23 for weekly for 4 weeks. Documentation to be provided.
- The DON and ADON will be responsible for ongoing compliance in this area.

Licensee's Proposed Overall Completion Date: 02/13/2023

Implemented (JM - 03/10/2023)

184a - Resident's Meds Labeled

10. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.

Description of Violation

The north hallway medication cart contained a jar of Major brand Minerin Cream. The prescription label was torn off and there was no resident name present.

Plan of Correction

Accept (JM - 02/24/2023)

- The label was printed and applied to the minerin cream on 1/25/23 by the ADON.
- Staff was re-trained on 2/8/23 on proper medication labeling by the DON and ADON.
- The DON and ADON will monitor each med cart weekly for 4 weeks to ensure compliance and then spot checks ongoing after that.
- The DON and ADON are responsible for compliance.

Licensee's Proposed Overall Completion Date: 02/13/2023

Implemented (JM - 03/10/2023)

227h - Support Plan Refuse Sign

11. Requirements

2600.

227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident 1's [redacted] participated in the development of the support plan completed [redacted]. The home did not make a notation regarding the resident's [redacted] refusal or inability to sign.

Plan of Correction

Accept (JM - 03/03/2023)

- The resident's [redacted] did participate in the development of the support plan on [redacted] by phone with the unit manager, however the manager failed to note the [redacted] participation on the form
- The unit managers were re-educated on 1/24/23 by the DON on the importance of documenting all those who

227h - Support Plan Refuse Sign (continued)

participate in the creation of the support plan

- The DON, ADON or designee will audit each new and existing support plan as they are completed and monthly going forward to ensure that the support plan is fully completed and all participants have signed or it is noted in some way
- All current and existing support plans will be audited by the DON, ADON or designee monthly to ensure it's ongoing compliance

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/10/2023)

254a - Records Discharge/Active

12. Requirements

2600.

254.a. Records of active and discharged residents shall be maintained in a confidential manner, which prevents unauthorized access.

Description of Violation

On 1/24/23, binders containing resident's prescription information were stored on top of the north central and south central hallway medication carts. The names of residents, medications, medical diagnoses, and purpose for medications, including for Resident 2, were unlocked, unattended, and accessible.

Plan of Correction

Accept (JM - 03/03/2023)

- On 1/24/23 the ADON immediately re-educated the medication associates verbally on the regulation for resident records and confidentiality
- Narcotic books which had been laying on top of medication carts unattended was removed upon inspection immediately by the ADON on 1/24/23.
- All medication associates and nurses were re-educated on 2/8/23 during a staff meeting by the DON and ADON on ensuring that all resident protected health information is locked at all times on the cart and in the nurses office
- Beginning on 2/9/23 the DON and or ADON will ensure ongoing compliance by monitoring the storage of confidential records and medications via direct observation 4 x per week x 4 weeks then 2 x week x 4 weeks, then weekly x 4 weeks to ensure protected health information is locked. If any confidential records are left out unattended on a medication cart or in open office, the observation process will restart the same frequency in the building where the error was identified until a full 12 weeks of monitoring without errors are completed.
- The DON and or ADON has created a form to document these checks on 2/9/23. The form has been reviewed and approved by the campus ED on 2/9/23 prior to our next quality meeting which is scheduled for March 2023
- The DON and or ADON is responsible for implementing and maintaining the acceptable plan of correction ongoing

Licensee's Proposed Overall Completion Date: 03/01/2023

Implemented (JM - 03/10/2023)