Department of Human Services

Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

November 13, 2023

EC OPCO LEWISBURG LLC

RE: CELEBRATION VILLA OF LEWISBURG
2421 OLD TURNPIKE ROAD
LEWISBURG, PA, 17837
LICENSE/COC#: 22720

Dear ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/17/2023 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *CELEBRATION VILLA OF LEWISBURG* **License #**: *22720* **License Expiration**: *03/01/2024*

Address: *2421 OLD TURNPIKE ROAD, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *EC OPCO LEWISBURG LLC*
Address: [redacted]
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/13/1998* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *43* **Waking Staff**: *32*

Inspection Information

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

Reason: *Monitoring, Interim* **Exit Conference Date**: *10/17/2023*

Inspection Dates and Department Representative

10/17/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *73* **Residents Served**: *42*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *42*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

10/17/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/10/2023*

11/09/2023 - POC Submission

Submitted By: [redacted] **Date Submitted**: *11/09/2023*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *11/14/2023*

Inspections / Reviews *(continued)*

11/13/2023 - Document Submission

Submitted By: [redacted]

Date Submitted: *11/09/2023*

Reviewer: [redacted]

Follow-Up Type: *Not Required*

25b - Contract Signatures

1. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract for Resident #1, dated [redacted]-23, is not signed by the resident.
The resident home contract for Resident #2 dated [redacted]-23, is not signed by the resident.

repeat violation 7/26/22

Plan of Correction ***Accept ([redacted] - 11/09/2023)***

Action: On 11/01/2023 all resident records were audited for resident signatures by the Executive Director and Regional Director of Operations.
Training: Executive Director was re-educated on regulation 2600.25.b. and proper procedure for contract signing on 11/02/2023 by Regional Director of Operations.
Ongoing: Executive Director will complete contracts with POA and residents at time of signing. Monthly audits of business charts will be conducted by the Executive Director or member of leadership team starting November 2023 and tracked using audit tool. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented ([redacted] - 11/13/2023)

54a - Direct Care Staff

2. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

The home did not have verification of a High School Diploma, GED, or active Nursing Aide Assistant registry for Staff A, hired on [redacted]/23.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: 11/03/2023 Staff member was notified of requirements and given 24 hours to submit proper documentation by Executive Director. High School Diploma was received on 10/19/2023. On 11/3/2023 all staff files were audited to ensure that they meet the qualifications required.
Training: All staff were educated on regulation 2600.54a. on 11/03/2023 by Executive Director.
Ongoing: Executive Director or member of leadership team will follow on-boarding checklist and track all necessary documents with a tracking device to ensure compliance by 11/06/2023. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented [redacted] - 11/13/2023)

81b - Resident Personal Equipment

3. Requirements

81b - Resident Personal Equipment *(continued)*

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 #3 has a halo safety ring attached to the bed. The Halo safety ring is not securely attached to the bed as it has movement from side to side due to the way the halo safety ring is attached to the bar that is attached to the bed. The device causes a safety hazard.

Repeat Violation 7/26/22

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: 10/17/2023 Halo was immediately adjusted, and an updated device was ordered by Director of Maintenance.
Training: All staff were re-educated on regulation 2600.81b on 11/03/2023 by Executive Director.
Ongoing: Daily checks will be conducted and documented in AccuFlo starting 11/06/2023 by Medication Technicians and/or nurse. Accuflo reports will be pulled weekly to audit for compliance by the Director of Nursing and/or Executive Director. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented (CP - 11/13/2023)

89a - Water Pressure

4. Requirements

2600.
89.a. The home must have hot and cold water under pressure in each bathroom, kitchen and laundry area to accommodate the needs of the residents in the home.

Description of Violation

A hot water temperature of 122.5 degrees was measured in the bathroom of room 113.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: 10/17/23 Director of Maintenance adjusted water temperature immediately during survey.
[redacted], HVAC company, was contacted on 10/17/2023. Responded and adjusted water temperature accordingly on 10/18/2023
Training: All staff were re-educated on regulation 2600. 89a on 11/03/2023 by Executive Director.
Ongoing: Starting 10/23/2023 Maintenance Director will conduct routine weekly temperature checks and log findings in TELS tracking tool. The Executive Director will monitor compliance starting 10/23/2023 by checking TELS reports. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented [redacted] 11/13/2023)

125a - Combustible Storage

5. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

125a - Combustible Storage *(continued)*

Description of Violation

A used dryer sheet and a sock were found behind the dryer in the laundry room of the home, posing a potential fire hazard.

Plan of Correction ***Accept (- 11/09/2023)***

Action: All items found were removed immediately on 10/17/2023 by housekeeping
Training: All staff were trained under regulation 2600. 125a on 11/03/2023 by Executive Director
Ongoing: Starting 11/03/2023 Housekeeping staff will check behind dryer for any combustible or flammable material daily and track using data tool. The Executive Director will monitor for compliance daily by checking log. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 11/13/2023)

132c - Fire Drill Records

6. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The homes fire drill log indicates a fire drill took place on 4/21/23 at 6:00am. However, the rest of the information for the drill was not completed on the record including amount of time to evacuate, exit routes used, number of residents in the home, number of residents evacuated, was alarm activated, was alarm operative, any problems, and planned corrective actions.

Plan of Correction ***Accept - 11/09/2023)***

Action: The current Maintenance Director looked for supporting documentation and it was not found on 10/17/2023
Training: Executive Director educated the Director of Maintenance and staff on regulation 2600.132c on 11/03/2023 by Executive Director.
Ongoing: Maintenance Director or leadership staff will conduct monthly fire drills and document using DHS fire drill log starting November 2023. The Executive Director will monitor for compliance monthly starting November 2023 by meeting with Maintenance Director. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 11/13/2023)

141a 1-10 Medical Evaluation Information

7. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

The documentation of Medical Evaluation for Resident #2, dated [redacted]-23, does not include the resident's height and weight.

The Documentation of Medical Evaluation for Resident #4 completed [redacted] 23, does not contain the date the resident was evaluated.

Repeat Violation 6/29/23

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: On 10/26/2023 Documentation of Medical Evaluation was updated by Primary care physician to include residents #2 height and weight. Resident #4 Documentation of Medical Evaluation was updated with information dated 08/22/2023.

Training: Director of Nursing was reeducated on regulation 141a on 11/03/2023 by Executive Director.

Ongoing: Starting 10/23/2023 Director of Nursing or leadership team members will conduct weekly audits and/or when a new Documentation of Medical Evaluation is received and completed. Documentation will be kept using auditing tool. The Executive Director will monitor for compliance with weekly meetings. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented [redacted] - 11/13/2023)

141b1 - Annual Medical Evaluation

8. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

The Documentation of Medical Evaluation completed [redacted]-23 for Resident #4 was completed late, as the previous Documentation of Medical Evaluation was completed on [redacted]-22.

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: On 10/25/2023 Documentation of Medical Evaluation was faxed to doctor's office. Updated Documentation of Medical evaluation dated [redacted]/2023 was received from physician on 11/07/2023.

Training: Director of Nursing was reeducated on regulation 2600.141.b.1 on 11/03/2023 by the Executive Director.

Ongoing: Starting 10/23/2023 Director of Nursing and member of leadership team will audit Documentation of Medical Evaluations by 10/31/2023. Audits will be conducted weekly to ensure compliance by the Director of

141b1 - Annual Medical Evaluation (continued)

Nursing and Executive Director starting 11/01/2023. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented (█ - 11/13/2023)

183b - Meds and Syringes Locked

9. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 10/17/23, at 12:45am, Department rep observed medication cart unlocked and unattended.

Repeat Violation 7/26/22

Plan of Correction ***Accept (█ 11/09/2023)***

Action: The Executive Director locked the Medication Cart immediately after it was reported to her by the Department representative.
Training: Director of Nursing and Medication Technicians were educated on regulation 2600.183 on 11/03/2023 by the Executive Director.
Ongoing: Starting 11/01/2023 Weekly audits will be conducted by the Director of Nursing and/or Executive Director and findings documented using a tracking tool and corrected if found. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented (█ - 11/13/2023)

183f - Discontinued Medications

10. Requirements

2600.
183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

The Novolog pen for Resident 5 was opened on 9/13/23 and expired on 10/11/23 but was still available at the time of inspection on 10/17/2023.

Plan of Correction ***Accept (█ - 11/09/2023)***

Action: The Novolog pen was removed from cart, destroyed immediately, and a new pen was put in place on 10/17/2023 by the Director of Nursing.
Training: Medication technicians were educated on regulation 2600.183 f on 11/3/2023 by the Director of Nursing.
Ongoing: Starting 10/17/2023 Each staff member will begin checking expiration dates. Cart audits are performed weekly by the Director of Nursing and Lead Medication Technician and tracked using a tracking system. All audits

183f - Discontinued Medications (continued)

will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 11/13/2023)

184b - Labeling OTC/CAM

11. Requirements

2600.
184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

Located in the top drawer of cart 3 was a bottle of fluticasone propionate 50mcg. The medication was not in the original box and the bottle did not have a label with a resident's name on it. In cart 2 was an empty box of the same medication. Staff B stated the bottle of medication in cart 3 belonged to the resident in cart 2.

Plan of Correction ***Accept - 11/09/2023)***

Action: Fluticasone was removed from cart immediately on 10/17/2023, a new order was placed, and medication was received on 10/18/2023.
Training: Medication technicians were educated on 11/03/2023 by the Director of Nursing and Executive Director on regulation 2600. 184 b.
Ongoing: Starting 10/23/2023 The Director of Nursing and Lead Medication Technician will conduct weekly Med Cart Audits and documentation kept. Executive director will monitor for compliance. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 11/13/2023)

185a - Implement Storage Procedures

12. Requirements

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

The Glucometer for Resident #5 was calibrated to the incorrect date and time. At 3:03pm on 10-17-23, the glucometer displayed a date of 4-1-23 and a time of 3:22am.

Plan of Correction ***Accept - 11/09/2023)***

Action: Glucometer was calibrated immediately by the Director of Nursing on 10/17/2023
Training: Medication technicians were trained on 11/03/2023 by the Director of Nursing on regulation 2600.185a
Ongoing: Starting on 11/01/2023 Glucometers are checked daily and documented by medication technicians. The Director of Nursing will monitor for compliance using glucometer spreadsheet weekly. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented - 11/13/2023)

227d - Support Plan Medical/Dental

13. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #3 uses a Halo Safety Ring. The Resident Assessment and Support Plan dated [redacted]-23 does not include the specific need for the device, the intended use, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, the specific device to be used, and if a cover is required to meet FDA guidelines.

Repeat Violation 12/7/22

Plan of Correction ***Accept [redacted] - 11/09/2023)***

Action: The Resident Assessment and Support Plan was updated on 10/19/2023 by Director of Nursing.
Training: Director of Nursing was educated on regulation 2600.227d on 11/03/2023 by Executive Director.
Ongoing: Starting 10/26/2023 Director of Nursing and Executive Director audited Resident Assessment and Support Plans for documentation on residents' halo devices to ensure proper verbiage for the need of the device, the intended use, any risks, and the residents' ability to use the device safety. The Executive Director will monitor compliance using the Resident Assessment and Support Plan audit tool. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented [redacted] - 11/13/2023)

227g -Support Plan Signatures

14. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The Resident Assessment Support Plan for Resident #4, dated [redacted]-22, was not signed by the resident. There was not a notation that the resident did not want to participate or was unable to sign.

Repeat Violation 7/26/22, 12/7/22

Plan of Correction ***Accept ([redacted] - 11/09/2023)***

Action: On 10/17/2023 Resident signed Resident Assessment Support Plan immediately after finding by Director of Nursing.
Training: The Director of Nursing was educated on regulation 2600.227.g on 11/03/2023 by the Executive Director.
Ongoing: Starting 10/26/2023 Director of Nursing or Executive Director will audit Resident Assessment Support Plan by 10/31/2023. Audits will be conducted weekly to ensure compliance by the Director of Nursing and Executive Director starting 11/01/2023. All audits will be reviewed at the monthly Quality Assurance meeting starting November 2023.

Licensee's Proposed Overall Completion Date: *11/09/2023*

Implemented (CP - 11/13/2023)