

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

March 22, 2024

[REDACTED]  
FAIRMOUNT HOMES  
[REDACTED]  
[REDACTED]

RE: FAIRMOUNT HOMES - FARM CREST  
1100 FARM CREST DRIVE  
EPHRATA, PA, 17522  
LICENSE/COC#: 32198

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/14/2024 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: FAIRMOUNT HOMES - FARM CREST License #: 32198 License Expiration: 05/18/2024  
Address: 1100 FARM CREST DRIVE, EPHRATA, PA 17522  
County: LANCASTER Region: CENTRAL

**Administrator**

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

**Legal Entity**

Name: FAIRMOUNT HOMES  
Address: [REDACTED]  
Phone: [REDACTED] Email: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 08/06/1998 Issued By: Labor & Industry

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 27 Waking Staff: 20

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Incident Exit Conference Date: 02/14/2024

**Inspection Dates and Department Representative**

02/14/2024 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
License Capacity: 38 Residents Served: 25  
Secured Dementia Care Unit  
In Home: No Area: Capacity: Residents Served:  
Hospice  
Current Residents: 0  
Number of Residents Who:  
Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 25  
Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 0  
Have Mobility Need: 2 Have Physical Disability: 1

**Inspections / Reviews**

02/14/2024 - Partial  
Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/04/2024

03/11/2024 - POC Submission  
Submitted By: [REDACTED] Date Submitted: 03/18/2024  
Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 03/18/2024

Inspections / Reviews *(continued)*

03/14/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/18/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 03/21/2024

03/22/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/18/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

## 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.

## Description of Violation

On [REDACTED], Resident [REDACTED] allegedly hit Resident [REDACTED] and pulled Resident [REDACTED] hair. On [REDACTED], Resident [REDACTED] was observed "ramming" [REDACTED] rollator into Resident [REDACTED] rollator. On [REDACTED], Resident [REDACTED] and Resident [REDACTED] were engaged in a verbal altercation. Resident [REDACTED] was overheard telling Resident [REDACTED] to stop hitting [REDACTED]. Upon assessment, Resident [REDACTED] informed staff that Resident [REDACTED] had hit [REDACTED] multiple times.

## Plan of Correction

Accept [REDACTED] - 03/11/2024)

1. Prior to [REDACTED] incident, personal care team had been communicating to family about ongoing conflict between Resident [REDACTED] and Resident [REDACTED], recommending psychiatry services for Resident [REDACTED] due to dementia with behaviors, and possible separation. Family refused all interventions. Social Services also met with Resident [REDACTED] and Resident [REDACTED] separately, offered separation and both parties refused. Both parties adamantly reported they feel safe. CRNP managing Resident [REDACTED] care managed medications for [REDACTED] with Behaviors. Continued verbal conflict occurred however able to be redirected by staff intervention.
2. On [REDACTED] and [REDACTED] following above listed incidents, immediate redirection was provided and couple was separated by staff. Resident [REDACTED] was assessed and had no injuries and reported he was okay. Resident [REDACTED] declined permanent separation in separate rooms. Family was made aware of incident and OOA contacted. Family continued to refuse psychiatry involvement for Resident [REDACTED] due to [REDACTED] with Behaviors, however after family meeting on [REDACTED], family agreed to psychiatry involvement to assist in managing Resident [REDACTED].
3. Resident [REDACTED] had initial consult with Supportive Care Psychiatry [REDACTED]. Staff continued to provide intervention, checks, and redirection as needed.
4. Family continued to refuse separation for their parents, feeling they have "always been this way" and they wanted them to stay together.

On [REDACTED] a family meeting was held to discuss Resident [REDACTED] physical decline and need for skilled nursing due to [REDACTED]. Discussed interventions in place, including staff redirection, offering snacks, visiting, 1:1 time, and [REDACTED] desire to always be with Resident [REDACTED]. At this point, there had been no more physical interactions, except verbal arguing and Resident [REDACTED] was considered stable. Family expressed a desire for both their parents to be moved to skilled nursing together as they continued to not want them separated.

1. Following family meeting on [REDACTED], above listed incident occurred. Staff provided multiple attempts at redirection throughout the night including snacks, talking, 1:1 and redirection. Temporarily effective. At [REDACTED] when above listed altercation occurred, staff provided reassurance, redirection, all ineffective for Resident [REDACTED] who continued with anxiety regarding spouse and delusions of [REDACTED] having affairs etc. PRN Ativan given following interventions to ease Resident [REDACTED] distress. Staff took Resident [REDACTED] for a walk and provided 1:1 to diffuse situation.
2. Resident [REDACTED] was assessed, no injuries. Resident [REDACTED] reported pain and that [REDACTED] does hit [REDACTED] when upset, but continued to refuse to leave room.
3. Immediate checks put in place. Couple did not want to be separated and due to time of incident and inability to immediately move Resident [REDACTED] couple was placed on 1 hour checks and stable.
4. Family notified of need to move Resident [REDACTED] to skilled nursing due to physical decline and and to protect Resident [REDACTED] from abuse. Family in agreement and requested Resident [REDACTED] be moved with [REDACTED].
5. OOA aware of situation and recommended separation. Due to this family agreed to Resident [REDACTED] moving to [REDACTED].

42b - Abuse (continued)

skilled nursing and Resident [redacted] remaining in Personal Care to ensure visits were supervised and time alone was not permitted.

6. Psychiatry managing Resident [redacted] care made aware and expressed concern for Resident [redacted] being without [redacted] spouse, however understanding due to [redacted] behaviors resulting from [redacted] [redacted] could not share a room with spouse.

7. Resident [redacted] moved to skilled nursing [redacted] at [redacted]

9. Any visits between Resident [redacted] and Resident [redacted] are now supervised by staff.

10. Resident [redacted] was referred to psychiatry services to support [redacted] mental health as [redacted] processes [redacted] [redacted] decline.

Additional Interventions

1. On 12/13/23 Admin assigned All staff Relias Module : December PC Abuse/OAPSA to be completed by 1/19/2024.

2. Admin reviewed PC Abuse Policies and remain appropriate as of 2/27/2024

3. Admin scheduled Staff Training to cover Abuse/OAPSA/Abuse Reporting on 3/6/2024 and 3/7/2024.

Proposed Overall Completion Date: 03/07/2024

Licensee's Proposed Overall Completion Date: 03/07/2024

Implemented [redacted] - 03/19/2024)

202 - Prohibitions

2. Requirements

2600.

202. The following procedures are prohibited:

- 4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.

Description of Violation

Resident [redacted] is prescribed medication to control episodic behaviors as described in the following orders: [redacted] every four hours as needed for anxiety, restlessness or agitation". Resident [redacted] received the PRN [redacted] "in an attempt to redirect behaviors".

Plan of Correction

Accept [redacted] - 03/14/2024)

1. LPN immediately reviewed if any residents currently had orders for PRN psychotropic medications prescribed to control episodic behaviors such as restlessness or agitation. None were found.

2. [redacted], CRNP that rounds at Farm Crest Personal Care twice weekly (and wrote above mentioned order) was educated by Director of Personal Care about PC regulation 2600.202 and importance of not prescribing a medication to control an episodic behavior on 2/27/24. CRNP in agreement to adjust [redacted] diagnoses to not reflect behaviors.

**202 - Prohibitions (continued)**

3. *Clinical Care Staff training to cover Chemical Restraints scheduled for [REDACTED] and [REDACTED] lead by Director of Personal Care.*
4. *Monthly Audits started on 3/1/24 to be completed x4, followed by quarterly audits starting 7/1/24 x4 to ensure appropriate diagnosis, appropriate documentation for administration including non-behavioral reason, and appropriate follow-up for effectiveness provided for PRN psychotropic medications by Director of Personal Care or designee.*
5. *If during audits an inappropriate diagnosis is found, Clinical care staff will request PCP correct the diagnosis. If during audits PRN psychotropic medications are not being administered appropriately staff will be re-educated by Director of Personal Care or designee and additional reporting to DHS as necessary will take place by Director of Personal Care or designee.*

**Licensee's Proposed Overall Completion Date:** 03/12/2024

**Implemented** [REDACTED] - 03/19/2024)