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

August 14, 2024

[redacted], CEO
ELM TERRACE GARDENS
[redacted]

RE: ELM TERRACE GARDENS
660 N. BROAD ST., 3RD & 4TH FL
LANSDALE, PA, 19446
LICENSE/COC#: 12783

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/29/2024 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: *ELM TERRACE GARDENS* **License #**: *12783* **License Expiration**: *06/10/2025*

Address: *660 N. BROAD ST., 3RD & 4TH FL, LANSDALE, PA 19446*

County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *ELM TERRACE GARDENS*

Address: [redacted]

Certificate(s) of Occupancy

Type: *Other* **Date**: *05/01/1992* **Issued By**: *Borough of Lansdale*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *121* **Waking Staff**: *91*

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *05/29/2024*

Inspection Dates and Department Representative

05/29/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *250* **Residents Served**: *80*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *24* **Residents Served**: *21*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *80*

Diagnosed with Mental Illness: *24*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *41*

Have Physical Disability: *3*

Inspections / Reviews

05/29/2024 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/27/2024*

07/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/12/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/14/2024*

Inspections / Reviews *(continued)*

07/22/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/12/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/13/2024*

08/14/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/12/2024*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15a Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701 10225.707) and 6 Pa. Code § 15.21 15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted], at [redacted], a jewelry theft occurred in the apartment of resident#1. This incident was reported to staff person A on [redacted]. However, this allegation of abuse was not reported to the local area agency on aging.

Plan of Correction ***Accept [redacted] - 07/09/2024)***

On [redacted] Staff person A reported possible theft to police, DHS, and placed call to adult protective services hotline. Following the attached instructions, an Act 13 form was not completed and submitted. On [redacted] Act 13 form was filled out and submitted at the guidance of DHS surveyors. Administrator or designee will submit an Act 13 form within 48 hours of an oral report to the local area on aging with any misappropriation of funds.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented [redacted] - 08/13/2024)

42b Abuse

3. 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] at around [redacted], Resident #1 reported missing jewelry from their apartment. Previously, on [redacted], Resident #1's family had brought several pieces of jewelry to the apartment, including a diamond ring, a Claddagh ring, a three-stone diamond ring, a gold pinky ring, and a diamond sapphire bracelet. According to Staff Member A, all personnel, including housekeeping, personal care, and maintenance, have a master key to the resident apartments. The home has no specific guidelines or policy regarding staff access to residents' apartments. Resident #1 mentioned that housekeeping staff have access to and is aware that staff have been in the apartment when he/she is not in their apartment.

On [redacted] an altercation between Staff Member A and Resident 2 was captured on a hidden video monitoring device that was placed in the residents room by the residents family. The home became aware of the incident after Staff Member C reported that resident #2 was found on the floor in their room during the safety check, which was completed at 7 am. The cause of the fall was initially unknown. Family of the resident reviewed the camera footage to determine the reason for the resident's fall when they discovered physical and verbal abuse by Staff Member B towards Resident 2. Which they then reported to the home. On [redacted], Resident 2 was lying on their side in bed when Staff Member B, entered their room, removed the blanket from the resident, and using both hands forcefully pushed on residents knees to push them to the side and over the edge of the bed while yelling "come on, get up!" and "let's go!" Staff Member B is then observed to walk away from the resident without further assisting resident out of bed, and instead leaving them lying awkwardly on the edge of bed, with their feet towards the ground. Staff Member B is then overheard yelling "I am not helping you up! Get Up!" Staff Member B then walks back towards Resident 2, screaming 'GET UP!" and then kick Resident 2 in the legs. Staff Member B briefly grasps Resident 2's hand and pushes resident's

42b - Abuse (continued)

legs again, saying "that's all I'm doing, get up". Resident 2 can then be seen slowly sliding off the side of the bed, while Staff Member B walks away. Staff Member B can be heard saying "I don't have time for this [resident's name] GET UP!" Resident #2 continues to slowly slide to the floor from the bed while Staff Member B can be heard yelling "If you fall to the floor I am not helping you up! Cause you could have got up yourself." Staff Member B is observed continuing to put away laundry in the room while resident is still slowly sliding to the floor Staff Member B can be seen looking directly at Resident 2 multiple times. Staff Member B continues to say "I'm not helping you up. NO! Get UP! You can stay just like that too!, You're lazy ok! You want someone always doing something for you that you can do yourself, so stop the BULLSHIT, I know what you are capable of doing, so stop it! I don't care if you stay like that. You'll see how much I am really helping you, and if you fall on the floor you will stay like that too!" At this point, Resident 2 is almost all the way out of the bed but their upper back is still awkwardly leaning back against the side and top of their bed. Staff Member B then says " I'm dead serious, I'm not helping you, you can get up on your own. BYE." Staff member then shuts a light in the vestibule of residents room, walks out of the apartment, closes the door. A moment later, Resident 2 can then be seen further sliding down and appears fully seated on the ground leaning back against the side of the bed. Staff Member B, re-enters the room with a laundry basket, looks directly at Resident 2 seated on the ground, and says "you can help yourself up" and walks out of the room again, closing the door. The entire interaction lasts approximately 4 minutes, however, Resident #2 then remained on the floor in their room from 6:15am until Staff Member C entered at approximately 7am.

Plan of Correction ***Accept ([redacted] - 07/22/2024)***

Immediate internal investigation into the theft and report to police. Policy Change for Maintenance and Housekeeping effective June 1, 2024 - master keys to be signed out when needed. Housekeeping/Maintenance Director will be responsible for maintaining this log. Staff is not to enter an occupied room without the resident present. Administrator and Community Educator will meet with all staff to review policy change and review of misappropriation of property. Meeting held 6/4/24, discussed again 6/18/24

***Correction: On 05/21/24 an altercation between 'Staff Member B' and Resident 2 was on a video monitoring device - device was not hidden and there was a posting that recording was in progress*

Staff Member B immediately terminated, reported to [redacted] Police, licensing agency, and local area on aging. Internal investigation conducted, skin assessments completed on residents under Staff Member B's care, all personal care residents and families informed of the incident. Staff training regarding abuse, act 13 mandatory abuse reporting, and virtual dementia tour- your window into their world. Community Educator will continue with Abuse education annually, Clinical Director or designee will review skin assessments and falls, noting any trends with shifts, assignments, etc. ongoing.

Licensee's Proposed Overall Completion Date: *07/09/2024*

Implemented [redacted] - 08/13/2024)

42s - Privacy

4. Requirements

42s - Privacy *(continued)*

2600.
42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On [redacted], around [redacted], an voice activated electronic device was present in resident#1's apartment. There is no notice posted outside the apartment door indicating the operation of an voice controlled device and that audio may be inadvertently recorded.

Plan of Correction ***Accept ([redacted] - 07/09/2024)***

Notice immediately posted on Resident #1 door. Audit completed for all resident rooms to ensure postings up to date. Checking for voice activated devices added to weekly rounding sheet for Administrator or designee to ensure postings up to date routinely.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented [redacted] - 08/14/2024)

65d - Initial Direct Care Training

5. 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 D, 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 [redacted] - 07/22/2024)***

Direct care staff person D is no longer employed, document of direct care training submitted did not have the date on it. Human Resources Director or designee began audit in July of employee files to ensure that needed documents are obtained and are clear copies. Going forward Human Resources Director or designee will monitor all incoming documents during the onboarding process to ensure to information is legible.

Licensee's Proposed Overall Completion Date: *07/24/2024*

Implemented [redacted] - 08/13/2024)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On May 29, 2024, at 10:30 am, a sign that displayed a red STOP sign and read "Do not enter" posted on the front door of the memory care unit on the 7th st. side, which is used as an emergency egress. The presence of the STOP sign presents an obstruction as it may cause a person to hesitate to use that door during an emergency.

121a Unobstructed Egress *(continued)*

Plan of Correction ***Accept (07/09/2024)***

Stop sign was immediately removed from the hallway door. Administrator and Maintenance Director rounded all Personal Care and Memory Care to ensure no other similar signage was posted on the doors. Monitoring signage on the egresses was added to the weekly rounding sheet to be conducted by the Administrator of designee.

Licensee's Proposed Overall Completion Date: *06/24/2024*

Implemented (- 08/14/2024)

234d - Support Plan Revision

8. Requirements

2600.
234.d. The support plan shall be revised at least annually and as the resident's condition changes.

Description of Violation

The assessment for Resident #2, dated , shows an 'A' (Independent) for 'Transferring in/out of bed/chair' and ambulation. However, Resident #2 experienced two falls, one on , and another on . The support plan dated , has not been updated to document this change in need or plan to address this need.

Plan of Correction ***Accept (- 07/22/2024)***

Resident #2 care plan immediately updated. Administrator or designee will complete weekly chart audits to review support plans starting in June until all charts have been reviewed. Clinical Director or designee will review falls monthly starting in July to ensure that necessary changes are reflected in support plans, this review will be ongoing.

Licensee's Proposed Overall Completion Date: *08/07/2024*

Implemented - 08/13/2024)