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

August 12, 2024

[redacted], ADMINISTRATOR
ELAN GARDENS INC
465 VENARD ROAD
CLARKS SUMMIT, PA, 18411

RE: ELAN GARDENS SENIOR LIVING A JEWISH SENIOR LIFE COMMUNITY
465 VENARD ROAD
CLARKS SUMMIT, PA, 18411
LICENSE/COC#: 24375

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/17/2024 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: *ELAN GARDENS SENIOR LIVING A JEWISH SENIOR LIFE COMMUNITY* **License #**: *24375* **License Expiration**: *06/03/2025*

Address: *465 VENARD ROAD, CLARKS SUMMIT, PA 18411*

County: *LACKAWANNA* **Region**: *NORTHEAST*

Administrator

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

Legal Entity

Name: *ELAN GARDENS INC*

Address: *465 VENARD ROAD, CLARKS SUMMIT, PA, 18411*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/18/1996* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *39* **Waking Staff**: *29*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *07/17/2024*

Inspection Dates and Department Representative

07/17/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *75* **Residents Served**: *38*

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**: *38*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

07/17/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/02/2024*

08/02/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/07/2024*

Inspections / Reviews *(continued)*

08/02/2024 - POC Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/07/2024*

08/05/2024 - Document Submission

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

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *08/10/2024*

08/12/2024 - Document Submission

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

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

The home did not have the License Inspection Summary report dated 6/8/23, et al posted conspicuously in the home as required.

Plan of Correction ***Accept (- 08/02/2024)***

a. A copy of the most recent survey from 6/7/2023 was placed on the public bulletin board at this time of inspection.
b. An audit was conducted on 7/18/2024 of the public bulletin board ensure required postings are present.
c. Executive Director completed an inservice on 7/25/2024 with Business Office staff on the required postings.
d. An audit of the public bulletin board will be conducted quarterly to be sure required postings are present and updated as necessary. Executive Director to monitor for ongoing compliance. Results of the audit will be reviewed for Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 08/02/2024)

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

Staff person A, who provides direct care to residents, has a high school diploma from a non-U.S. secondary school. The home did not have a waiver in place to approve staff member A's education requirement.

Plan of Correction ***Accept (- 08/02/2024)***

a. A waiver was requested for the identified staff person with a non-U.S. secondary diploma.
b. Executive Director conducted an audit of current direct care staff qualifications to identify any additional staff that may not meet the educational criteria.
c. Executive Director conducted an inservice on 7/26/2024 with Business Office Manager to identify any non-U.S. diplomas prior to onboarding.
d. Executive Director will monitor new direct care hires to monitor for continued compliance. Results of the audit will be reviewed for Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 08/02/2024)

81b - Resident Personal Equipment

3. Requirements

2600.

81b - Resident Personal Equipment *(continued)*

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 #1 uses an enabler bar for transfers out of bed. The enabler bar was not firmly secured to the bed and could be moved easily from side to side.

Plan of Correction ***Accept (- 08/02/2024)***

a. Resident #1 enabler bar was tightened to the bed during inspection.
b. An audit was conducted by the maintenance director on 7/25/2024 of other enabler bars/bed canes used in the facility to ensure they are firmly secured to the bed(s).
c. Executive Director conducted an inservice on 7/25/2024 with maintenance staff on firmly securing enabler bars/bed canes to the bed.
d. A quarterly audit of in-house bed canes/enablers to be completed by maintenance director to ensure they are firmly secured to the bed. Executive Director to monitor for ongoing compliance. Results of the audits will be reviewed for Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 08/12/2024)

103i - Outdated Food

4. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

The home's walk-in refrigerator contained 4 bags of romaine lettuce that appeared to be brown and spoiled.

Plan of Correction ***Accept (- 08/02/2024)***

a. The identified lettuce was removed from the refrigerator upon identification and returned to the supplier for a refund.
b. Director of Dietary Services completed an audit of produce in the refrigerator to identify and remove food that was outdated or spoiled.
c. Executive Director completed an inservice on 7/26/2024 with dietary staff regarding spoiled or outdated food and having the same removed from the kitchen.
d. Director of Dietary Services will complete a weekly audit of delivered produce to identify and remove any spoiled or outdated items. Audit results will be reviewed for Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented (- 08/12/2024)

132a - Monthly Fire Drill

5. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

132a - Monthly Fire Drill *(continued)*

Description of Violation

During the fire drill conducted on 6/30/23 at 6:30am only 39 of the 40 residents present in the home were evacuated. One resident fell during the fire drill and was not evacuated, therefore the home did not have a fire drill completed for the month of June 2023.

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. The 6/30/2023 fire drill cannot be conducted.
b. An audit was conducted on 7/18/2024 of previously held fire drills for 2024 to identify any failed fire drill.
c. Executive Director to conducted an inservice on 7/26/2024 with current staff on fire drill evacuation and the priority to evacuate in-house residents within the timeframe identified by the fire official.
d. Executive Director to monitor completed fire drills to ensure they are completed successfully. Executive Director to monitor for compliance and Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/12/2024)

132g - Fire Drills Days/Times

6. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home's sleeping hour drills were conducted on the following dates and times:
4/18/24 at 6:35am; 11/30/23 at 10:35pm; 6/30/23 at 6:30am. All three fire drills were conducted with 7 staff present in the home. The home's direct care staff schedule indicates that the home's 3rd shift schedule ranges from 10:45pm to 7:15pm with 3 to 4 staff persons scheduled overnight. The home has regularly scheduled sleeping hour drills during times when additional staff are present in the home to assist in evacuating residents.

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. A sleeping successful hour fire drill was conducted on 7/30/2024 with routinely scheduled night shift staff members in the building.
b. Executive Director conducted an inservice on 7/26/2024 with the Director of Maintenance on conducting a sleeping hour fire drill every six months at times when designated night shift staff are present in the building.
c. Executive Director will monitor sleeping hour fire drills for ongoing compliance and Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/12/2024)

183e - Storing Medications

7. Requirements

2600.

183e - Storing Medications *(continued)*

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 small refrigerator located in the medication room had a temperature reading of 50°F when it was checked twice during the medication audit. The refrigerator is used to store unopened insulin pens. According to the manufacturer, unopened insulin pens must be stored at temperatures between 36° and 46° F.
The Incruse Ellipta inhaler for resident #2 was not labeled with the initials and date the inhaler was removed from the foil package.

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. Medication room refrigerator thermometers were replaced with a new digital thermometer. The current temperature reading in the refrigerator is 40 degrees. The identified Ellipta inhaler is missing the original box due to the resident bringing the item from home. The inhaler was replaced by pharmacy and is in a box with the pharmacy label attached to the outside.
b. Nurse consultant conducted an inservice on 7/18/2024 medication storage, including, refrigerator temperatures and storage criteria with current nursing/med tech staff.
c. Medication cart audits to be conducted weekly by nursing/med tech staff to identify items present that do not meet storage criteria and resolve. Nursing/Med Tech staff to complete daily temperature logs on the medication room refrigerators to ensure correct temperature is being maintained.
d. Director of Resident Care Services and Executive Director will monitor for ongoing compliance and Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/05/2024)

184a - Resident's Meds Labeled

8. 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.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

The Incruse Ellipta inhaler for resident #2 was found in the medication cart with no pharmacy label attached to it.
The Medication administration record (MAR) for resident #3 indicates the resident has an order for Diazepam 1 tablet at bedtime. The pharmacy label for the medication indicates the order is 1 tablet two times pers day.

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. The identified Ellipta inhaler was replaced with a new inhaler in proper packaging with medication label securely attached to the outside of the box. An "Order Change" sticker was applied to the Diazepam pack to instruct staff to

184a - Resident's Meds Labeled (continued)

review the physician's order before administration.
b. Nurse consultant conducted an inservice on 7/18/2024 on medication labels and the criteria required for medications stored in the medication cart.
c. Medication cart audits to be conducted weekly by nursing/med tech staff to identify items in the medication carts that do not meet medication label criteria and resolve.
d. Director of Resident Care Services and Executive Director will monitor for ongoing compliance and Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/12/2024)

187d - Follow Prescriber's Orders

9. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

On 7/10/24 staff person B administered two 100mg tablets of the medication Celebrex to resident #4. Resident #4's correct order for the medication is one 100mg tablet two times daily as needed. The medication error occurred due to a pharmacy packaging error.
Resident #3 has an order for Metoprolol 1 tablet in the morning, afternoon, and at bedtime. The order includes the instructions to hold the medication for Systolic Blood Pressure (SBP) less than 140. On the following dates the medication was administered at times when the SBP was less than 140:
7/16/24 at 2pm the SBP was 115
7/14/24 at 9am the SBP was 136
7/12/24 at 2pm the SBP was 119

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. The identified medication error was reported to the department at the time of the occurrence. The current supply of Celebrex was removed from the medication cart, the pharmacy was contacted, and a new supply of Celebrex with the correct dosing/packaging was obtained. The resident demonstrates no ill effects.
Resident #3 physician was notified of Metoprolol being administered outside the ordered parameters on the dates identified. The resident demonstrates no ill effects.
b. Nurse consultant conducted an inservice on 7/18/2024 on following prescriber's orders, including ordered parameters, Rights of Medication Administration, and the triple check process with current nursing/Med Tech staff.
c. Director of Resident Care Services completed an audit of residents with parameters with medications for the last 4 weeks to identify any additional issues.
d. Director of Resident Care Services and/or Executive Director will complete a daily audit for 2 weeks to ensure medication is being given per the physician orders.

Licensee's Proposed Overall Completion Date: *07/31/2024*

Implemented ([redacted] - 08/12/2024)

227d - Support Plan Medical/Dental

10. 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 #1 uses a bedside mobility device to help transfer out of bed. The resident's Support Plan dated [redacted] does not note the specific need for the device, any risks associated with the device, the resident's ability to use the device safely for the intended purpose, and if a cover is required to meet FDA guidelines.

Plan of Correction ***Accept ([redacted] - 08/02/2024)***

a. RASP addendum was completed for the identified resident to reflect the specific need, risks, and resident's ability associated with the bed mobility device on 7/29/2024.
b. Director of Resident Care Services conducted an audit on 7/18/2024 of current RASPs of residents with bedside mobility devices on to identify additional information needed. RASPs updated as needed.
c. Executive Director conducted an inservice on 7/18/2024 with Director of Resident Care Services on the required information on the RASP pertaining to bedside mobility devices.
d. Executive Director will monitor for ongoing compliance and Quality Assurance purposes.

Licensee's Proposed Overall Completion Date: *08/02/2024*

Implemented ([redacted] - 08/12/2024)