

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

January 14, 2025

[REDACTED]
ELM TERRACE GARDENS
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/16/2024 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]
Phone: [REDACTED] **Email:** [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:** *129* **Waking Staff:** *97*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**
Reason: *Incident* **Exit Conference Date:** *10/16/2024*

Inspection Dates and Department Representative

10/16/2024 **On Site:** [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *250* **Residents Served:** *81*

Secured Dementia Care Unit

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

Hospice

Current Residents: *7*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *81*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *48* **Have Physical Disability:** *2*

Inspections / Reviews

10/16/2024 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** *POC Submission* **Follow Up Date:** *11/10/2024*

Inspections / Reviews *(continued)*

11/15/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2024

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 11/20/2024

11/20/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 01/01/2025

01/14/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/30/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

42c Treatment of Residents

1. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

Description of Violation

On [REDACTED] at 6:30 A.M. Staff Member A and Staff Member B woke Resident [REDACTED] up to provide morning care. According to Staff Member A, Resident [REDACTED] was combative and resistant to care, and attempted to strike both staff members. Staff Member A attempted to get the resident cleaned up and dressed. Resident [REDACTED] was standing up and wanted to transfer from standing to [REDACTED] wheelchair independently. According to the [REDACTED] resident assessment and support plan (RASP), the resident is unable to transfer safely without staff assistance. During the attempted transfer, Resident [REDACTED] told staff "no" and moved Staff Member A's hands away. Resident [REDACTED] from a standing position, was lowering themselves into the wheelchair. Staff Member A grabbed the back of Resident [REDACTED]'s pants and lowered them down into the wheelchair. Resident [REDACTED] punched Staff Member A in their right arm. Staff Member A then took the back of their hand and tapped Resident [REDACTED] on Resident [REDACTED] left shoulder and stated "if you hit me, I hit you back."

Plan of Correction

Accept [REDACTED] - 11/20/2024)

On [REDACTED], The Personal Care Administrator immediately initiated an internal investigation which resulted in suspending staff member A and providing reassurance to resident [REDACTED].

On [REDACTED], Nurse Educator immediately conducted an in-service on Abuse and Neglect prevention and detection. Meeting reviewed the different types of abuse, and abuse reporting, resident bill of rights, The Elder justice Act, Person Centered care, and work burn out strategies.

On [REDACTED], Staff member A's employment was terminated.

On October 15, 2024, and ongoing, The POC and monitoring process will be discussed during quarterly QAPI meetings by the Executive Director and/or Clinical Director. If not effective, it will be amended and new POC will be implemented and monitored to verify compliance with the regulation.

On 10-15-24 and 11/18/24 Nurse Educator immediately conducted an in-service on Abuse and Neglect prevention and detection for all departments who work in Personal Care. An updated sign in sheet is being attached listing employee's department they work in.

On 11/18/24, Personal Care Administrator started random weekly audits with residents 1:1 to discuss abuse and resident's rights. Audits on 1:1 meeting with residents will continue until 12-31-24. Also, on 11/18/24 Administrator has started weekly observations of staff and resident interactions. Audits for these observations will continue until 12-31-24.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented [REDACTED] - 01/14/2025)

42c Treatment of Residents (continued)

183e - Storing Medications

3. 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

On [redacted] at 1:30 P.M. Resident [redacted] s [redacted] one tablet twice daily as needed, the blister pack was punctured in slot 37 and taped over.

Plan of Correction

Accept [redacted] 11/20/2024)

Medication in slot [redacted] was removed and properly destroyed by Clinical Director on [redacted]

On [redacted], Clinical Director along with Lpn staff checked all medication cards and examined blister cards to make sure cards are completely sealed.

On November 7, 2024 Training was conducted by Nurse Educator to all employees trained in medication administration on Managing controlled substances on medication cart.

Random audits will be conducted weekly by Clinical Director and (or) Nursing staff to make sure all medication stored in blister cards are free from any breaks, tears in the individual seals.

Starting 11/18/24, Weekly audits of medications carts will be conducted by Personal Care Wellness Director to make sure all medication blister cards are sealed properly.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented ([redacted] - 01/14/2025)

201 - Positive Interventions

4. Requirements

2600.

201. Safe Management Techniques - The home shall use positive interventions to modify or eliminate a behavior that endangers the resident himself or others. Positive interventions include improving communications, reinforcing appropriate behavior, redirection, conflict resolution, violence prevention, praise, deescalation techniques and alternative techniques or methods to identify and defuse potential emergency situations.

Description of Violation

Resident [redacted], becomes agitated and aggressive about care. According to the 6/7/24 and 9/25/24 resident assessment and support plans, staff are to approach Resident [redacted] calmly, give a choice about care times, then later re approach while explaining steps of care provided, and lastly call Resident [redacted] spouse if needed. The home has not implemented positive interventions to modify or eliminate the behavior. On [redacted], Staff Person A provided care to Resident [redacted] and lowered Resident [redacted] by their pants into a wheelchair after Resident [redacted] said "no." and pushed Staff Member A's hands away when offering care. Staff Member B was present and supervising during this care and did not re direct Staff Member A. During an interview, Staff Member A could not explain the steps of how to re direct Resident [redacted] Staff

201 Positive Interventions (continued)

Member A reported to only getting out of Resident way and trying to re approach in a different way. Staff Member A could not provide examples of re approaching in a better way.

Plan of Correction

Accept - 11/20/2024)

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On , Staff member A's employment was terminated.

On October 15, 2024, and ongoing, The POC and monitoring process will be discussed during quarterly QAPI meetings by the Executive Director and/or Clinical Director. If not effective, it will be amended and new POC will be implemented and monitored to verify compliance with the regulation.

On 10 15 24 and 11/18/24 Nurse Educator immediately conducted an in service on Abuse and Neglect prevention and detection for all departments who work in Personal Care. An updated sign in sheet is being attached listing employee's department they work in.

On 11/18/24, Personal Care Administrator started random weekly audits with residents 1:1 to discuss abuse and resident's rights. Audits on 1:1 meeting with residents will continue until 12 31 24. Also, on 11/18/24 Administrator has started weekly observations of staff and resident interactions. Audits for these observations will continue until 12 31 24.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented - 01/14/2025)

202 - Prohibitions

5. Requirements

2600.

202. The following procedures are prohibited:

- 5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.

Description of Violation

On at approximately 6:30 A.M. Staff Member A provided morning care to Resident with Staff Member

202 - Prohibitions (continued)

B. Resident [redacted] was cleaned up and dressed. Resident [redacted] was standing up and wanted to transfer independently to Resident [redacted] wheelchair. According to [redacted] resident assessment and support plan Resident [redacted] is unable to transfer safely without staff assistance. Staff Member A offered to assist Resident [redacted] and Resident [redacted] stated "no." and pushed Staff Member A's hands away. Staff Member A then lowered Resident [redacted] into their wheelchair by the back of their pants as Resident [redacted] was trying to independently sit in the wheelchair. Resident [redacted] then punched Staff Member A in their arm.

Plan of Correction

Accept [redacted] - 11/20/2024)

On [redacted], The Personal Care Administrator immediately initiated an internal investigation which resulted in suspending staff member A and providing reassurance to resident [redacted]

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On 11/18/24, Personal Care Administrator started random weekly audits with residents 1:1 to discuss abuse and resident's rights. Audits on 1:1 meeting with residents will continue until 12-31-24. Also, on 11/18/24 Administrator has started weekly observations of staff and resident interactions. Audits for these observations will continue until 12-31-24.

Proposed Overall Completion Date: 12/31/2024

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented [redacted] - 01/14/2025)