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

April 28, 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 02/10/2025, 02/14/2025, 02/21/2025, 02/25/2025 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**: *116* **Waking Staff**: *87*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *02/25/2025*

Inspection Dates and Department Representative

02/10/2025 - On-Site: [redacted]
02/14/2025 - Off-Site:
02/21/2025 - Off-Site:
02/25/2025 - Off-Site:

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**: *22*

Hospice

Current Residents: *8*

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: *35* **Have Physical Disability**: *0*

Inspections / Reviews

02/10/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/23/2025*

Inspections / Reviews *(continued)*

03/25/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/18/2025*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *03/30/2025*

03/31/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *04/18/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/18/2025*

04/28/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *04/18/2025*

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] Resident's family reported to the home that Resident [redacted] was missing [redacted] from brown wallet kept in Resident's dresser. The home did not report this to the local area agency on aging.

Plan of Correction ***Accept ([redacted] - 03/31/2025)***

The previous Administrator and Clinical Director failed to report this incident to the area agency on aging. Since this event, there is a new Administrator and Clinical Director. Each have completed the Abuse training including Older Adult Protective Services Act reporting requirements and Department of Human Services Reportable Incident requirements. There have been 2 incidents since this survey that have warranted initiating those reporting requirements and the reporting requirements were followed exactly. We had a visit from DHS on 3/10/2025 to investigate and was satisfied with the reporting of both incidents.

Steps going forward were initiated on 2/10/2025 following our inspection from DHSL to include daily review of all reported incidents by the Administrator, Clinical Director, or Nurse Supervisor to determine necessary next steps for each incident. This is accomplished through review of our Point Click Care software, written 24 hour communication logs, and collaboration at our daily stand-up clinical meetings. Responsibility for further reporting actions is and will continue to be that of the Administrator or Clinical Director. This will remain an ongoing process. Instruction to these processes will be reviewed with staff and reinforced with all new staff in orientation going forward.

Licensee's Proposed Overall Completion Date: *04/18/2025*

Implemented ([redacted] - 04/28/2025)

23a - Activities of Daily Living Assistance

2. Requirements

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [redacted] assessment and support plan (RASP), dated [redacted], indicates the resident requires assistance with supervision. Under "Supervision", the RASP states that staff will frequently check the placement of the resident's wander guard and chair alarm. The home uses these alarms as tools to monitor the resident due to the resident's wandering behaviors. The resident does not reside in a secured unit, and has attempted to leave the home on numerous occasions and is exit-seeking. On [redacted], and [redacted] at 10:00 P.M., the resident did not receive this assistance as required.

Plan of Correction ***Directed [redacted] - 03/31/2025)***

While the resident was receiving the supervision and assistance, the staff failed to document such on the above

23a Activities of Daily Living Assistance (continued)

dates. Staff will be in serviced on the importance of consistent and accurate documentation of the tasks that they perform throughout their shift.
Immediate steps to this violation involved investigation of why documentation did not occur, evaluation of the procedures in place for documentation, plain for procedural improvement. Plan for improvement involve utilizing our EMar system to document safety related checks deemed necessary more accurately. This process will begin by 4/15/25, evaluated for efficiency by 4/30/25. Should this system be successful, fully in place by 5/1/2025.

Proposed Overall Completion Date: 05/02/2025

Directed Plan of Correction:

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall provide education to all direct care and nursing staff of the requirements to provide Actiity of Daily Living support to residents as directed in the Resident Assessment and Support Plan.

Starting within 10 days of the date of the receipt of the acceptable plan of correction, the administrator or designee shall perform audits of the eMAR system and/or observations weekly for three weeks, then monthly for two months to ensure staff are providing care as described in the resident assessment and support plan.

Directed Completion Date: *04/15/2025*

Implemented [redacted] - 04/28/2025)

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 4:30 P.M., Staff Member A performed a blood pressure check on Resident [redacted] then transported the resident to the dining room and left the resident unattended. At 4:50 P.M., Staff Member's A and B heard the [redacted] alarm, which alerts staff when a resident wearing a wander guard enters or leaves certain spaces, and responded to the alarm to look for Resident [redacted] The resident was found on the landing at the bottom of the first level of stairs in stairwell 2 laying on their left side with their wheelchair on top them. Resident [redacted] had a skin tears on both hands and arms but no other visible injuries. Staff Member A observed an expression of discomfort on the resident's face but the resident did not verbalize pain and tried to stand up without assistance. Resident [redacted] was assessed by the nurse who requested emergency medical assistance via 911. The resident was transported to the hospital by ambulance and was admitted with a diagnosis of subdural hemorrhage. Resident [redacted] was discharged from the hospital to a skilled nursing facility and passed away on [redacted].

According to Resident [redacted] record, on [redacted] the resident had tried to exit the home 3 times via stairwells 10 and 2. The home had a care conference with the Power of Attorney (POA) on [redacted] about the resident's need for the secured dementia care unit (SDCU) due to repeated exiting seeking behaviors. The resident's most recent medical evaluation, dated [redacted] indicates a diagnosis of unspecified [redacted]. On [redacted] Resident [redacted]s POA stated they would like to wait to transfer them to the SDCU. Resident [redacted] was prescribed [redacted] 1 tablet per day

42b - Abuse (continued)

for anxiety. Per the POA's request and physician's order, the lorazepam was discontinued on [redacted]. The Resident Assessment and Support Plan (RASP), dated [redacted], indicates that the resident requires extensive supervision. " [Resident [redacted]] needs supervisor all of the time. [redacted] is an elope risk. [redacted] is a wanderer and ambulates using a wheelchair. [redacted] is confused in familiar surroundings. [redacted] is unable to leave the unit on [redacted] own. [redacted] is equipped with a wander guard as well" The home's plan to address [redacted] supervision need does not specify the frequency of the needs for staff to supervise the resident and states only "Staff will frequently check [resident [redacted]] whereabouts to maintain safety. And to check if wander guard/chair alarm is in use and properly working."

Repeat Violation: [redacted] et al

Plan of Correction ***Directed [redacted] - 03/31/2025)***

The previous Administrator and Clinical Director had met with the POA who declined the proposed move to the SDCU. The current Administrator and Clinical Director have reviewed the RASPs of any individual who potentially poses a risk for elopement. One resident was identified as a risk. The Administrator and Clinical Director implemented 1:1 care for the individual and worked with the POA to have [redacted] moved to the SDCU within 24 hours. The plan of correction going forward is that any resident deemed at risk requiring extensive supervision will be required to have 1:1 care in place immediately or move to a more secure environment such as the SDCU or Skilled Nursing Home within our Community. The home will provide 1:1 care for 24 hours until arrangements can be made by the POA.
Review of all resident RASPs began on 1/27/2025 upon arrival of the new Administrator and Clinical Director. RASP audits have continued and will continue for each resident annually, upon significant change, and/or in response to a specific incident warranting review or update of the RASP. Currently, we do not have any individual posing an elopement risk. This will be an ongoing process managed by the Administrator and Clinical Director.

Proposed Overall Completion Date: 04/18/2025

Directed Plan of Correction:

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate all direct care and nursing staff on abuse and abuse prevention and reporting, to include reporting behaviors of residents exceeding the care needed described in the resident assessment and support plan.

Starting within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit a sample of at least 10 residents and corresponding support plans per month for three months to ensure that the support plan has been updated to reflect the residents' most current needs. All Resident Assessment and Support Plans requiring revision shall be completed by the administrator or designee within 5 days of identifying the residents' needs.

Directed Completion Date: *04/15/2025*

Implemented [redacted] - 04/28/2025)

227h - Support Plan Refuse Sign

4. Requirements

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident [redacted] participated in the development of [redacted] support plan on [redacted] The Resident was unable to sign the support plan. The home did not make a notation regarding the resident's inability to sign.

Plan of Correction ***Directed [redacted] - 03/31/2025)***

Administrator audited all resident files to ensure for accuracy and completion. The This Administrator is to be responsible for the final review of the RASP prior to being entered into the chart. In the event of the Administrator's absence, the Clinical Director will revies for accuracy and completion.

Review of all current resident RASPs began on 1/27/2025 upon arrival of the new Administrator and Clinical Director. RASP audits have continued and will continue for each resident annually, upon significant change, and/or in response to a specific incident warranting review or update of the RASP. This will be an ongoing process managed by the Administrator and Clinical Director.

Proposed Overall Completion Date: 04/18/2025

Directed Plan of Correction:

Within 15 days of the receipt of the acceptable plan of correction, the administrator shall educate all staff who perform evaluations and complete support plans of the requirements of 227h.

Starting within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall audit a sample of at least 10 newly completed Resident Assessment and Support Plans monthly for 3 months.

Directed Completion Date: *04/15/2025*

Implemented [redacted] - 04/28/2025)