STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395474	A. BLDG: 00 B. WING:	02/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LECOM AT ELMWOOD GARDENS, LLC STATE LICENSE NUMBER: **680202**	**2628 ELMWOOD AVENUE** **ERIE, PA 16508**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1 Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey completed on February 13, 2025, it was determined that LECOM at Elmwood Gardens was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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F 0641 SS=A	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	I hereby acknowledge the CMS 2567-A, issued to LECOM AT ELMWOOD GARDENS, LLC for the survey ending 02/13/2025, AND attest that all deficiencies listed on the form will be corrected in a timely manner.	Completion Date: **03/14/2025** Status: **APPROVED** Date: **03/05/2025**

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F 0641 SS=A	Continued from page 3 Based on review of Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), clinical records and staff interviews, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the status for one of 12 residents reviewed (Resident 37). Findings include: Review of MDS instructions for Section H "Bladder and Bowel" subsection H0100 "Appliances" indicated to check each appliance that was used at any time in the past seven days. Section H "Bladder and Bowel" subsection H0300 "Urinary Continence" indicated that urinary continence is to be coded as "not rated" if during the seven-day look-back period the resident had an indwelling bladder catheter (tubing inserted from the bladder to drain urine into the bag), condom catheter, ostomy, or no urine output for the entire seven days. Resident R37's clinical record revealed an admission	F 0641		

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F 0641 SS=A	Continued from page 4 date of 10/10/23, with diagnoses that included congestive heart failure (CHF - progressive heart disease that affects the pumping action of the heart resulting in difficulty breathing and tiredness), and multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and neurogenic bladder (when the nerves or the brain cannot communicate effectively to the muscles in the bladder). Resident R37's clinical record revealed a physician's order dated 10/21/24, for an Indwelling Catheter. Resident R27's quarterly MDS with an Assessment Reference Date of 11/07/24, Subsection H0100 "Appliances" was coded as "None of the above" and Subsection H0300 "Urinary Continence" was coded as "Always Incontinent", although Resident R37 had an indwelling catheter for the entire seven-day look-back period. During an interview on 2/12/24, at 11:02 a.m. Registered Nurse Assessment Coordinator	F 0641		

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F 0641 SS=A	Continued from page 5 confirmed that the 11/07/24, MDS was coded inaccurately and should have been coded as having an "indwelling catheter" and urinary continence should have been coded as "not rated" for Resident R37. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical Records	F 0641		
F 0711 SS=D		F 0711		

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F 0711 SS=D	Continued from page 6 483.30(b)(1)-(3) Physician Visits - Review Care/Notes/Order §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 0711	Residents R26, R36, R37 and R42 orders have all been signed/dated by the Elmwood medical staff. Nursing Home Administrator notified the Elmwood medical staff of this noncompliance, and the medical team immediately reviewed, signed and dated all applicable orders. All other residents' orders have been reviewed by the Elmwood medical staff and all other residents' orders are in compliance with being signed/dated by the appliable Elmwood medical staff. Physician orders education has been provided to the Elmwood medical staff regarding the requirement of timeliness in reviewing and signing off on resident orders; education was conducted by Nursing Home Administrator. Director of Nursing or designee will conduct whole house audits to ensure compliance with the signing and dating of all orders. Audits will be conducted weekly for 4 weeks,	Completion Date: **03/14/2025** Status: **APPROVED** Date: **03/10/2025**

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F 0711 SS=D	Continued from page 7	F 0711	biweekly for 4 weeks and then monthly for 2 months. Results of these audits will be reviewed at the quarterly quality assurance meeting; any unfavorable auditing results will result in immediate corrective action step(s).	

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F 0711 SS=D	Continued from page 8 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that the physician signed and dated all orders during each of his/her visits for four of 12 residents reviewed (Residents R26, R36, R37, and R42). Findings include: A facility policy entitled "Physician Services" dated 11/14/24, indicated that physician orders and progress notes are maintained with current regulations. Resident R26's clinical record revealed an admission date of 2/25/21, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), high blood pressure, and endocarditis (inflammation of the inner lining of the heart chambers and valves usually caused by bacterial infection). Resident R26's physician's orders revealed that	F 0711		

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F 0711 SS=D	Continued from page 9 7/02/24, at 9:59 a.m. was the last time his/her physician reviewed, signed, and dated his/her physician's orders. Resident R36's clinical record revealed an admission date of 2/09/24, with diagnoses that included high blood pressure, stroke resulting in paralysis of left side, and hypothyroidism (a condition resulting from decreased production of thyroid hormones). Resident R36's physician's orders revealed that 7/02/24, at 9:59 a.m. was the last time his/her physician reviewed, signed, and dated his/her physician's orders. Resident R37's clinical record revealed an admission date of 10/10/23, with diagnoses that included congestive heart failure (CHF-progressive heart disease that affects the pumping action of the heart resulting in difficulty breathing and tiredness), and multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), and neurogenic bladder (when the nerves	F 0711		

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F 0711 SS=D	Continued from page 10 or the brain cannot communicate effectively to the muscles in the bladder). Resident R37's physician's orders revealed that 7/02/24, at 9:59 a.m. was the last time his/her physician reviewed, signed, and dated his/her physician's orders. Resident R42's clinical record revealed an admission date of 11/14/24, with diagnoses that included diabetes, high blood pressure, and CHF. Resident R42's physician's orders revealed that his/her physician orders had not been reviewed, signed, and dated by his/her physician. During an interview on 2/12/25, at 11:02 a.m. Registered Nurse Assessment Coordinator confirmed that the physician orders for Residents R26, R36, R37, and R42 were past due for being reviewed and signed by the physician During an interview on 2/13/25, at 8:50 a.m. the	F 0711		

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F 0711 SS=D	Continued from page 11 Director of Nursing (DON) confirmed that physician orders for Residents R26, R36, and R37 should have been signed every sixty days and were not signed in September 2024, November 2024, or January 2025 as required. The DON also confirmed that Resident R42's physician orders should have been signed in November 2024 at the time of admission and every thirty days thereafter for the first ninety days, which included December 2024 and January 2025. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(i) Medical records	F 0711		
F 0712 SS=D		F 0712		

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F 0712 SS=D	Continued from page 12 483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 0712	Resident R42 was seen by the physician on 02/25/2025. All other resident records have been reviewed for their last physician visit date to ensure ongoing compliance with the timeliness of their physician visits. Education has been provided to the Elmwood Medical Staff regarding the minimal frequency of physician visits requirements, education was conducted by the Nursing Home Administrator. Director of Nursing or designee will conduct whole house audits to ensure compliance with frequency/timeframes of required physician visits; whole house audits will be conducted weekly for 4 weeks, then biweekly for 4 weeks and then monthly for 2 months. Results of these audits will be reviewed at the quarterly quality assurance meeting; any unfavorable auditing will result in immediate	Completion Date: **03/14/2025** Status: **APPROVED** Date: **03/10/2025**

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F 0712 SS=D	Continued from page 13	F 0712	corrective action step(s).	

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F 0712 SS=D	Continued from page 14 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least every 30 days for the first 90 days after admission for one of eight new admissions reviewed (Resident R42). Findings include: A facility policy entitled "Physician Services" dated 11/14/24, indicated that physician visits, frequency of visits, emergency care of residents, etc. are provided in accordance with current regulations. Resident R42's clinical record revealed an admission date of 11/14/24, with diagnoses that included diabetes, high blood pressure, and congestive heart failure. Resident R42's clinical record progress notes revealed he/she was seen by the Certified Registered Nurse Practitioner on 11/18/24, and 12/16/24. The clinical record lacked evidence that	F 0712		

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F 0712 SS=D	Continued from page 15 he/she was seen in January 2025 as required by the physician. During an interview on 2/13/25, at 9:24 a.m. the Director of Nursing confirmed that Resident R42 was not seen by the physician as required in January 2025. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(ii)(vii) Medical records	F 0712		
F 0812 SS=E		F 0812		

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F 0812 SS=E	Continued from page 16 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	All refrigerators were checked, and proper cleaning and disposal of items was completed immediately upon discovery by the surveyors. All staff were educated on the importance of checking and cleaning refrigerators. Family members and residents were provided with a copy of the Outside Food policy. Refrigerator cleaning logs were immediately put into place, the dietary department or designee will clean and properly dispose of any undated, unlabeled, or expired supplies in the refrigerators and keep log. The nursing home administrator or designee will conduct audits weekly for 4 weeks, and then monthly for 3 months. This will include checking to ensure logs are being kept and properly completed as well as observing refrigerators to ensure compliance. Results of these audits will be	Completion Date: **03/14/2025** Status: **APPROVED** Date: **03/11/2025**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=E	Continued from page 17	F 0812	reviewed at the quarterly quality assurance meeting; any unfavorable auditing results will result in immediate corrective action step(s).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395474	A. BLDG: 00 B. WING:	02/13/2025

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F 0812 SS=E	Continued from page 18 Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in two of two resident refrigerators (Melrose Unit and Linden Lane); failed to label food brought into the facility with the resident's name and use by date; and failed to maintain sanitary conditions in one of two resident refrigerators (Melrose Unit). Findings include: Review of facility policy entitled, "Food Brought by Family/Visitors," dated 11/14/24, revealed that perishable foods are to be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the "use by" date and that nursing staff will discard perishable food on or before the "use by" date. Review of facility policy entitled, "Food Receiving and Storage," dated 11/14/24, revealed that food	F 0812		

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F 0812 SS=E	Continued from page 19 services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all times. All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date). Review of facility policy entitled "Foods and Snacks kept on Nursing Units," dated 11/14/24, revealed that all foods belonging to residents are labeled with the resident's name, the item and the "use by" date. Observations on 2/10/25, at 2:48 p.m. revealed a refrigerator on Melrose Unit used for residents contained a sandwich in a sealed container with a resident name but no "use by" date; a sandwich in a sealed container with a resident name and "use by date" of 2/07/25; and six sealed Activia yogurts labeled with a resident name and expiration date of 1/23/24. Inside the refrigerator, the bottom door shelf contained a pink/sticky liquid substance. The freezer contained a blue/sticky substance coating the bottom of the base of the freezer under the freezer drawer and multiple old, discolored ice cubes.	F 0812		

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F 0812 SS=E	Continued from page 20 During an interview on 2/10/25, at 2:55 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that the refrigerator contained a sandwich lacking a use by date, a sandwich that was past the use by date, and six Activia yogurts that expired on 1/23/24, and stated they should be discarded. LPN Employee E2 also confirmed the refrigerator contained a pink sticky liquid substance and the freezer contained blue sticky substance and old discolored ice cubes and needed cleaned. Observations on 2/12/25, at 9:45 a.m. revealed a refrigerator on Melrose Unit used for residents that contained five sealed cottage cheese cups with a use by date of 2/11/25. During an interview on 2/12/25, at 9:48 a.m. LPN Employee E1 confirmed that the five sealed cottage cheese cups were expired and should be discarded. Observation on 2/12/25, at 10:11 a.m. revealed a refrigerator on Linden Lane used for residents that	F 0812		

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F 0812 SS=E	Continued from page 21 contained a sealed plastic container with blueberry cobbler with a resident's name on it and a use by date of 1/28/25, and also contained an eleven ounce bottle of Ensure nutritional drink with an expiration date of 8/2024. During an interview on 2/12/25, at 9:48 a.m. Registered Nurse Employee E3 confirmed that the resident who the blueberry cobbler was for, discharged from the facility and also that it was past the use by date, the Ensure drink was expired, and both should have been discarded. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management	F 0812		
F 0880 SS=E		F 0880		

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F 0880 SS=E	Continued from page 22 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Water retested by Maintenance Director on 02/14/2025, samples sent to Special Pathogens Lab, results obtained by facility on 02/21/2025, all tests came back negative. Education provided to Maintenance Director regarding Legionella testing and facility water management plan by Nursing Home Administrator. Legionella testing to be completed as indicted in Infection Control plan. Nursing Home Administrator will audit to ensure Legionella testing is being completed quarterly, as indicated in Infection Control plan. Results of these tests will be reviewed at quarterly quality assurance meeting.	Completion Date: **03/14/2025** Status: **APPROVED** Date: **03/10/2025**

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F 0880 SS=E	Continued from page 23 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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F 0880 SS=E	Continued from page 24	F 0880		

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F 0880 SS=E	Continued from page 25 Based on review of facility policy and infection control records, and staff interviews, it was determined that the facility failed to ensure measures were in place to monitor and prevent legionella in the facility water. Findings include: A facility policy, "Infection Prevention and Control Plan FY2024," dated 11/14/24, revealed the infection control plan describes the process for the detection, prevention, and control of healthcare-associated infections (HAI), and disease transmission among residents, visitors, and healthcare personnel (HCP) (i.e., staff, providers, contractors/vendors, volunteers, and students). Water is tested at least quarterly for waterborne pathogens including Legionella. Response to positive test results is prescribed in the WMP (Water Management Plan). Facility policy, "Legionella Water Management Program," dated 11/14/24, revealed the facility is	F 0880		

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F 0880 SS=E	Continued from page 26 committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation further indicated the facility will have a system to monitor limits and the effectiveness of control measures, a plan for when control limits are not met and/or control measures are not effective, and documentation of the program. Review of facility water management records, "Special Pathogens Laboratory - The Legionella Experts" dated 10/10/24, revealed positive results for "Legionella rubrilucens" in Linden Lane Room 27, and positive results for "L. pneumophila, not serogroups" in the Skilled Hall Med Room. The facility lacked evidence of further testing for Legionella of the facility water system after 10/10/24. An interview with the Maintenance/Environmental Services Director on 2/13/25, at 9:25 a.m. revealed the facility received the positive findings for Legionella in the above noted areas on 10/10/24;	F 0880		

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F 0880 SS=E	Continued from page 27 Flushing of the facility water system with 160-degree water was completed, but no further testing of the water system for Legionella was completed after 10/10/24. He/she further confirmed that testing for Legionella should have been completed after the 10/10/24, positive results of Legionella, to ensure the usage of facility water was safe for all persons. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(d) Resident care policies	F 0880		

Certified End Page

LECOM AT ELMWOOD GARDENS, LLC

STATE LICENSE NUMBER: 680202

SURVEY EXIT DATE: 02/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY