

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

June 26, 2023

[REDACTED], AUTHORIZED REPRESENTATIVE
CAPITOL OPERATOR LLC
[REDACTED]
[REDACTED]

RE: THE TERRACES AT CAPITOL VILLAGE
4004 LINGLESTOWN ROAD
HARRISBURG, PA, 17112
LICENSE/COC#: 33798

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/13/2023, 04/20/2023 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]
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: THE TERRACES AT CAPITOL VILLAGE License #: 33798 License Expiration: 06/01/2023
Address: 4004 LINGLESTOWN ROAD, HARRISBURG, PA 17112
County: DAUPHIN Region: CENTRAL

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: CAPITOL OPERATOR LLC
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: 1 2 Date: 12/17/2001 Issued By: Lower Paxton Township

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 53 Waking Staff: 40

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
Reason: Renewal, Complaint Exit Conference Date: 04/13/2023

Inspection Dates and Department Representative

04/13/2023 On Site: [REDACTED]
04/20/2023 Off Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information			
License Capacity: 64	Residents Served: 48		
Secured Dementia Care Unit			
In Home: No	Area:	Capacity:	Residents Served:
Hospice			
Current Residents: 6			
Number of Residents Who:			
Receive Supplemental Security Income: 0	Are 60 Years of Age or Older: 48		
Diagnosed with Mental Illness: 0	Diagnosed with Intellectual Disability: 0		
Have Mobility Need: 5	Have Physical Disability: 1		

Inspections / Reviews

04/13/2023 - Full

Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 05/08/2023

Inspections / Reviews *(continued)*

05/22/2023 POC Submission

Submitted By: [REDACTED] Date Submitted: 06/14/2023
Reviewer: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 05/29/2023

06/02/2023 POC Submission

Submitted By: [REDACTED] Date Submitted: 06/14/2023
Reviewer: [REDACTED] Follow Up Type: Document Submission Follow Up Date: 06/12/2023

06/26/2023 Document Submission

Submitted By: [REDACTED] Date Submitted: 06/14/2023
Reviewer: [REDACTED] Follow Up Type: Not Required

105g - Lint Removal and Duct Cleaning

1. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 4/13/23, there was an approximate 0.75 inch accumulation of lint in the lint trap of the dryer in the third-floor laundry room. The dryer was not in use and there were no clothes in the dryer at the time.

Plan of Correction

Accept (█ - 05/15/2023)

- 1. The dryer lint visible was immediately removed, and the unit was immediately cleaned by Maintenance Director.
- 2. Maintenance Director immediately scheduled outside vendor to come on site on 4/25/23 to provide full service cleaning of all machines in the PC and the duct work leading to the external part of the building. This was completed on 4/25/23 as scheduled.
- 3. Maintenance Director Audited all Dryers in the PC and performed thorough cleaning of all Lint on 4-14-23.
- 4. Maintenance Director was inserviced on 4/13/23 on Cleaning of the Dryer Vents following the protocol in TELS (work order and preventative maintenance computerized system).
- 5. Maintenance Director trained all Maintenance Assistants on proper use of TELS, assuring knowledge of where to find thorough instructions on all maintenance tasks including the dryer vent cleaning.
- 6. Executive Director will assure random audits are performed 3x each week for 2 month to determine that re-education has been effective in assuring there is no lint observed in the dryers.

Licensee's Proposed Overall Completion Date: 05/12/2023

Implemented (█ - 06/20/2023)

132c - Fire Drill Records

2. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The exit route used for evacuation is not documented on the fire drill records from October 2022 through March 2023.

The total number of residents evacuated is not documented on the fire drill records from April 2022 through March 2023. The records indicate only the number of residents evacuated from the simulated fire/emergency area, rather than the total number of residents who participated in the drill.

Plan of Correction

Accept (█ - 05/15/2023)

- 1. Executive Director, Maintenance Director, Regional Plant Operations Director, and VP of Plant Operations met virtually on 4/28/23 with DHS licensing representatives to discuss this violation and seek guidance on corrective measures.
- 2. On 4/28/23 Facility's Vice President of Plant Operations spoke Croker Fire Safety to review findings and educate on DHS expectations for documentation.

132c Fire Drill Records (continued)

4. Executive Director will audit the Fire Drill Record monthly for 3 months to assure all facility residents present at the time of the drill have participated in the drill and this is accurately recorded on the Croker Fire Drill Record.

Licensee's Proposed Overall Completion Date: 05/12/2023

Implemented ([REDACTED] - 06/20/2023)

183d - Prescription Current

3. Requirements

2600.

183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On [REDACTED] [REDACTED] caplets, prescribed for Resident #1, were found in the home's medicine cart; however, this medication for this resident was previously discontinued and not found on the Medication Administration Record (MAR).

Plan of Correction

Accept ([REDACTED] - 06/02/2023)

- 1. Resident #1 [REDACTED] caplet was removed from the med cart and destroyed by the Wellness Director on 4/13/23.
- 2. Executive Director will conduct Med Cart Audits of all 3 med carts by 4 14 23 to assure the facility does not have discontinued medications stored in the facility.
- 3. Wellness Director will conduct re education with all Med Techs and LPN's on proper disposal methods for discontinued medications.
- 4. Wellness Director will conduct Med Cart Audits weekly for 3 months to monitor for the presence of discontinued medications starting 4/18/23.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented ([REDACTED] - 06/20/2023)

183e - Storing Medications

4. 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] the following insulin pens found in the medication cart were not labeled as to the date they were opened:

- [REDACTED] prescribed to Resident #2 which had a pharmacy label dated [REDACTED]
- [REDACTED] prescribed to Resident #2 which had a pharmacy label dated [REDACTED].
- [REDACTED] prescribed to Resident #3.
- [REDACTED] prescribed to Resident #3.
- [REDACTED] units prescribed to Resident #4.
- [REDACTED] prescribed to Resident #4.

According to the manufacturer's instructions, insulin has an expiration date based on the date of opening.

183e Storing Medications (continued)

Plan of Correction

Accept [REDACTED] - 06/02/2023)

1. On 4/13/23 Wellness Director immediately removed the identified insulin pens to determine pharmacy fill date and identify corrective action. The Wellness Director determine Resident 2 was admitted on [REDACTED], the [REDACTED] flexpen in use had a pharmacy fill date of 4 13 23. A date opened was placed on the [REDACTED] flex pen for 4 13 23 and returned to the med cart. The [REDACTED] dated 1 4 23 was from prior to admission and was destroyed. Resident 2's [REDACTED] dated 12/30/22 was from prior to admission and not in use. The [REDACTED] in use was filled by the pharmacy on 4 11 23, Wellness Director placed date opened on this pen of 4 11 23 and returned to the Med Cart. Resident #3 Fiasp Flextouch was filled by the pharmacy on 4 12 23, a date opened for 4 12 23 was placed on this pen and returned to the med cart. Resident #3 [REDACTED] pen was filled by the pharmacy on 4 13 23 and a date opened was placed on the pen for 4 13 23 and it was returned to the med cart. Resident #4 [REDACTED] was filled by the pharmacy on 4 12 23, a date opened of 4 12 23 was placed on this pen and returned to the med cart. Resident #4 [REDACTED] was filled by the pharmacy on 4 13 23, a date opened of 4 13 23 was placed on the pen and returned to the med cart. Wellness Director verified that all insulin pens in use were not expired per manufacturer's instructions.
2. Executive Director will conduct full med cart audits to verify that all insulins are accurately labelled with a date opened completed on 4/14/2023.
3. Wellness Director will conduct re education of Med Techs and LPN's on Proper Use and Storage of Medications per manufacturer's guidelines completed on 5/3/2023.
4. Wellness Director will conduct weekly audits x 3 months of Med Carts to monitor compliance of medications requiring a date opened to monitor for expiration beginning on 4/18/2023.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented [REDACTED] - 06/20/2023)

183f - Discontinued Medications

5. Requirements

2600.

- 183.f. Prescription medications, OTC medications and CAM that are discontinued, expired or for residents who are no longer served at the home shall be destroyed in a safe manner according to the Department of Environmental Protection and Federal and State regulations. When a resident permanently leaves the home, the resident's medications shall be given to the resident, the designated person, if any, or the person or entity taking responsibility for the new placement on the day of departure from the home.

Description of Violation

An unopened [REDACTED] prescribed to Resident #5 was found in the medication cart. This medication had an expiration date of [REDACTED].

Plan of Correction

Accept [REDACTED] - 06/02/2023)

1. On 4/13/23 Wellness Director removed and destroyed the 1.76 ounce tub of Vicks Vaporub that was found in the med cart expired.
2. Wellness Director reviewed with resident the desire to continue to have this medication available due to non use in the past 30 days. Resident expressed desire to have this medication available for use, and Wellness Director requested a refill of this medication to have available.
3. Executive Director will conduct a full med cart audit to determine if there are other medications on hand in the

183f Discontinued Medications (continued)

facility that are expired completed on [REDACTED]. The Wellness Director will remove expired medications. The Wellness Director will then request refills from the pharmacy and/or seek orders to discontinue medications not used in the past 30 days.

4. Wellness Director will re educate Med Techs and LPN's on monitoring expiration dates on medications, and the process for requesting refills completed on 5/3/2023.

5. The Wellness Director will conduct med cart audit weekly for 3 months to monitor compliance to assure there are no expired medications in the facility beginning on 4/18/2023.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented [REDACTED] - 06/20/2023)

184b - Labeling OTC/CAM

6. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

Description of Violation

On [REDACTED], an opened and partially used four (4) ounce tube of [REDACTED] was found in the 100 hall medication cart and was not labeled with a resident's name or other identifying characteristics such as room number.

Plan of Correction

Accept [REDACTED] - 06/02/2023)

1. On 4/13/23 Wellness Director removed the 4 ounce tube of [REDACTED] from the 1st floor med cart as it was not able to be identified. This medication was destroyed. The Wellness Director conducted an audit of facility current orders electronically and determined there were no active orders for [REDACTED] for residents in the community.

2. Executive Director will conduct full med cart audit to determine if all medications have a resident name identified with the medication completed on 4/14/2023.

3. Wellness Director will re educate Med Techs and LPN's on procedure to assure all medications are labelled with resident name completed on 5/3/2023.

4. Wellness Director will conduct weekly Med Cart Audits for 3 months to monitor compliance with labelling all medication with a resident name beginning 4/18/2023.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented [REDACTED] - 06/20/2023)

185a - Implement Storage Procedures

7. Requirements

2600.

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On [REDACTED] the blood glucose reading on Resident #3's glucometer was [REDACTED]. It was incorrectly recorded on the MAR as [REDACTED]

On [REDACTED] at [REDACTED], the blood glucose reading on Resident #3's glucometer was [REDACTED]. However, this reading was not recorded on the MAR.

185a - Implement Storage Procedures (continued)

The Glucometers for Residents #2, #6, #7 and #8 were calibrated for the correct date; however, not the correct time. On [REDACTED], Resident #2's glucometer showed [REDACTED]. On [REDACTED], Resident #6's glucometer showed [REDACTED]. On [REDACTED], Resident #7's glucometer showed [REDACTED]. On [REDACTED], Resident #8's glucometer showed [REDACTED].

Plan of Correction

Accept ([REDACTED] - 06/02/2023)

1. On 4/13/23 Wellness Director immediately calibrated Resident #2, #6, #7, #8 glucometers. Wellness Director reviewed documentation for the incorrect recording of the blood glucose and accurately struck out the recordings and edited the correct documentation for Resident #3.
2. On 4/14/23 Wellness Director audited all residents who have a glucometer to verify calibration and implement corrective action.
3. Wellness director will provide re-education to Med Tech's and LPN's on assuring Glucometers are calibrated correctly each time they are utilizing the glucometer completed on 5/3/2023.
4. Wellness Director will conduct weekly random audits x 3 months to verify compliance and implement corrective measures beginning on 4/18/2023.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented ([REDACTED] - 06/20/2023)

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

The following medications were not administered the following residents as prescribed:

Resident #3 is prescribed a blood sugar check and [REDACTED] units of [REDACTED]. On [REDACTED] and [REDACTED], neither of these were administered as prescribed. The resident is also prescribed [REDACTED] units of [REDACTED] solution before meals. The resident did not receive this injection on [REDACTED] at [REDACTED] at [REDACTED] and [REDACTED] at [REDACTED] and [REDACTED] at [REDACTED].

Resident # 9 is prescribed [REDACTED] applied to left [REDACTED] at bedtime. The resident did not receive this treatment on [REDACTED] and [REDACTED] at [REDACTED].

Resident # 10 did not receive the following medications on [REDACTED]: [REDACTED] doses of [REDACTED] tablet [REDACTED]. [REDACTED] also did not receive [REDACTED] dose of [REDACTED] nor [REDACTED] gel treatment for [REDACTED] knees as prescribed.

Plan of Correction

Accept ([REDACTED] - 06/02/2023)

1. On 4/13/23 Wellness Director informed the physicians of Resident #3, #9, and #10 on medications identified as not administered.
2. Wellness Director will conduct a full audit of the MAR's for April 13 to April 30th to determine if other medications were not received and will notify physicians of those residents as identified.
3. Wellness Director will conduct re-education on documentation expectations of Med Tech's and LPN's in the MAR to include how to address if a medication is not available, the proper steps to obtain the medication, documentation of resident refusals completed on 5/3/2023.

187d - Follow Prescriber's Orders (continued)

4. The Wellness Director will conduct MAR audits 5x per week beginning 5/1/23 to monitor medications being given as prescribed.

Licensee's Proposed Overall Completion Date: 06/08/2023

Implemented () - 06/20/2023)

224a - Preadmission Screen Form**9. Requirements**

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #9's preadmission screening form, dated (), does not include a determination that the needs of the resident can be met by the services provided by the home.

Resident #10's preadmission screening form, dated (), has an incomplete second page including all portions of Section II-J (personal care and medical needs, sensory needs, medical/physical/behavioral diagnoses, and if they are safe around poisonous materials). In addition, the form does not include a determination that the needs of the resident can be met by the services provided by the home.

Plan of Correction

Accept () - 06/02/2023)

1. Executive Director updated Resident 9 and Resident 10 Preadmission Screening forms on () to reflect complete and accurate document – both residents are appropriate for personal care.
2. Executive Director will complete full audit of all residents newly admitted to the facility since 6-1-22 to verify accuracy of Preadmission Screening Form completed by 5/1/2023.
3. Executive Director will conduct training on the Pre-Admission Screening form to the Community Relations Director and Wellness Director completed on 5/3/2023.
4. Executive Director will audit new admissions on or prior to date of physical admission for the next 3 months to assure complete and accurate documentation, and assure prospective resident is appropriate for personal care beginning 4/17/2023.

Licensee's Proposed Overall Completion Date: 06/01/2023

Implemented () - 06/20/2023)