November 12, 2019

Mr. David MacKenzie
Program Director
Mentor ABI, LLC
6816 West Lake Road
Fairview, Pennsylvania 16415

RE: Neurorestorative Pennsylvania
Certificate #: 446630

Dear Mr. MacKenzie:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 31, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

RECEIVED
10/1/19
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *NEURORESTORATIVE PENNSYLVANIA* **License Number:** *44663*
Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA 16415*
County: *ERIE* **Region:** *WESTERN*

Administrator

Name: *Emily Brown* **Phone:** *8144741977* **Email:** *DAVID.MACKENZIE@NEURORESTORATIVE.COM*

Legal Entity

Name: *MENTOR ABI LLC*
Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA, 16415*

Certificate(s) of Occupancy

Type: *I-1* **Date:** *01/26/2015* **Issued By:** *Fairview Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *16* **Waking Staff:** *12*

Inspection

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

Inspection Dates and Department Representative

07/31/2019 - On-Site: Desmond Grace

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served:** *8*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *8*
Are 60 Years of Age or Older: *2*
Diagnosed with Mental Illness: *8*
Diagnosed with Intellectual Disability: *2*
Have Mobility Need: *8*
Have Physical Disability: *0*

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Direct care staff person A, hired 9/8/15, did not receive fire safety training completed by a fire safety expert during the January 1, 2018 to December 31, 2018 annual training year.

Direct Care staff person B, hired 1/28/17, did not receive fire safety training completed by a fire safety expert during the January 1, 2018 to December 31, 2018 annual training year.

Plan of Correction (POC)

(Attach pages as necessary Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again If steps cannot be completed immediately include dates by which the steps will be completed.)

- Staff Person A and B did not receive Fire Safety Training in 2018.
- In March of 2019 all Program Administrators received Employee Fire Safety/ Train-the-Trainer training. (See Attached)
- Starting in March of 2019, the program Administrators are completing Fire Safety Training as part of the program's Annual Day Training
- Direct Care Staff B took this training in June of 2019. Staff Person A is scheduled for the training in November of 2019.
- Training needs are reviewed as part of the program's Quality Management process.

Legal Entity Representative

During the next quality management plan review and ongoing- the home will place an increased emphasis on these plans of correction and take action to improve the quality of its staff training plan to address annual completion of fire safety training by all staff. 10/10/19

The administrator or designated staff person will review all staff records in the home and ensure compliance with §2600.65(g)(1). 10/10/19

Signature: Dave McKenzie P.D. — Printed Name and Title — Date: 9/20/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 10/10/19 (Date)

Plan of correction implementation status as of 10/10/19 (Date)

- ☐ Fully Implemented
- ☑ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

The above plan of correction was approved by ______ (Initials)

96a - First Aid Kit

Regulations

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

At 3:00 p.m., the first aid kit located in the staff office did not include a thermometer.

Repeat violation: 8/10/18

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- The thermometer was located in the Med Room and placed back in the First Aid Kit at the time of inspection. (See Attached)
- The Administrator or designee completes the attached First Aid Kit Inventory Checklist monthly to ensure all items are in place. The completed checklist is sent to the QI Specialist for review.
- The program purchased a seperate thermometer to keep in the Med Room as the thermometer from the First Aid Kit was often left in there.

Legal Entity Representative

[signature] Dave MacKenzie P.D. 9/20/19

Signature | Printed Name and Title | Date

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141b1 - Annual Medical Evaluation

Regulations

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #2's annual medical evaluation, dated 7/26/18, did not include an evaluation of the resident's body positioning/movement. This section of the form was blank.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- Attached is the updated Medical Evaluation, which was completed on 8/15/19, and includes information regarding Resident #2's body positioning/movement.

- Moving forward, the program is updating the Medical Binder Chart review to ensure there are no blank sections. (see Attached) These chart audits are completed by the Case Managers quarterly.

Within 30 days of receipt of this plan of correction, all case managers responsible for reviewing medical evaluations will be educated on the changes to the medical binder chart review, the importance of ensuring completion of all sections of the medical evaluation document and the procedure for having the form completed if the medical evaluation is returned to the home incomplete. 10/10/19

Legal Entity Representative

Signature	Printed Name and Title	Date
[signature]	Dave MacKenzie P.D.	9/20/19

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183e - Storing Medications

Regulations

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

Resident #1 was prescribed Lantus insulin-inject 15 units subcutaneously every morning. The medication expired on 6/1/19; however, on 7/31/19, it was still present in the home.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- The expired medication was removed from the cart at the time of inspection.
- The program's Nursing Staff are completing the attached Medication Cart Checklist during monthly med cart Audits. Any expired meds are to be removed from the cart.
- The checklist is forwarded to the Health Services Supervisor and QI Specialist for review. This review will occur monthly and coincide with medication cart audits. [initials] 10/10/19

Legal Entity Representative

[signature]

Signature

Dave MacKenzie P.D.

Printed Name and Title

9/20/19

Date

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185a - Implement Storage Procedures

Regulations

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

Resident #1 was prescribed a weekly blood glucose check. On 7/3/19 at 8:00 a.m., a blood glucose reading of 98 was documented on the resident's medication administration record. However, the blood glucose reading was not present on the resident's glucometer for that date and time.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- The program revised the Nursing monthly Medication Cart checklist to include a check to ensure glucometer readings are accurate and reflect what is listed on the MAR. Any discrepancies will result in staff education and possible retraining on glucometer use. (see Attached revised checklist)
- During the program's next Staff Meeting on 10/23/19, the Health Services Supervisor will review with Staff the need to ensure glucometer readings are accurate and reflect what is on the MAR.

Within 30 days of receipt of this plan of correction, the administrator or designated staff person will audit all glucometers in the home to ensure that all blood glucose checks recorded on the glucometers are documented on resident's MARs. [initials] 10/10/19

Legal Entity Representative

The administrator or a designated staff person will review glucometer readings monthly during medication cart audits and compare glucometer readings with the readings documented on the medication adminstration record to ensure completeness and accuracy. [initials] 10/10/19

[signature]	Dave MacKenzie	9/20/19
Signature	Printed Name and Title	Date

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225a - Assessment 15 Days

Regulations

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #3 was admitted to the home on 12/26/18; however, the resident's assessment was not completed until 4/29/19.

Repeat Violation: 8/10/18

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

- When a resident transfered from one licensed home to another, regardless of physical address, the program completed a relocation checklist that followed the guidelines from the DHS Q/A - Regulatory Clarification from April 2016.
- Moving forward, the program developed a revised relocation checklist to include necessary documentation and assessments when a resident changes from a physical address. (see Attached)
- These change to our process were reviewed with program Administrators and case managers on 9/13/19. See attached sign-in sheet from meeting.

Legal Entity Representative

At least monthly, the administrator or designated staff person will review resident assessments for all newly admitted residents to ensure compliance with §2600.225(a). [initials] 10/10/19

[signature]	Dave MacKenzie P.D.	9/20/19
Signature	Printed Name and Title	Date

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