



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: [rkraft@srcare.org](mailto:rkraft@srcare.org)  
[filatifi@srcare.org](mailto:filatifi@srcare.org)

MAILING DATE: April 15, 2020

Ms. Roberta Kraft, PCHA  
The Presbyterian Homes in the Presby of Lake Erie, Inc  
2628 Elmwood Avenue  
Erie, Pennsylvania 16508

RE: Elmwood Gardens  
of Presbyterian Senior Care  
License #: 447650

Dear Ms. Kraft:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 20, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Mazza".

Larry Mazza  
Human Services Licensing Supervisor

Enclosure  
Licensing Inspection Summary

## Violation Report

### Facility Information

Name: *ELMWOOD GARDENS OF PRESBYTERIAN SENIOR CARE*  
Address: *2628 ELMWOOD AVENUE,, ERIE, PA 16508*  
County: *ERIE* Region: *WESTERN*

License Number: *44765*

### Administrator

Name: *Bobbi Kraft* Phone: *8149201220* Email: *RKRAFT@SRCARE.ORG*

### Legal Entity

Name: *THE PRESBYTERIAN HOMES IN THE PRESBY OF LAKE ERIE*  
Address: *2628 ELMWOOD AVENUE, ERIE, PA, 16508*

### Certificate(s) of Occupancy

Type: *C-1* Date: *04/03/1967* Issued By: *Dept L&I*

### Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *30* Waking Staff: *23*

### Inspection

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

### Inspection Dates and Department Representative

*02/20/2020 - On-Site: Amy Duncan, Lori Gillette*

### Resident Demographic Data as of Inspection Dates

#### General Information

License Capacity: *35* Residents Served: *20*

#### Secured Dementia Care Unit

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

#### Hospice

Current Residents: *0*

#### Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *20*  
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*  
Have Mobility Need: *10* Have Physical Disability: *1*

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.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Ancillary staff person A, hired 10/8/18, did not receive annual training on the following topics during the 2019 training year:

- \* Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert
- \* Emergency preparedness procedures and recognition and response to crises and emergency situations

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.)

Ancillary staff member A did not receive fire safety and emergency preparedness training in 2019 as she is a high school student who typically only works 4-9 during the school year. Our former fire safety expert from the Erie Fire Department retired in 2020.

Our maintenance director Jeff McKinley was trained in fire safety and emergency preparedness by a fire safety expert. (See attachment #1) Ancillary staff person A was trained in fire safety on 3/23/2020. (See attachment #2) By having one of our staff members trained as a fire safety expert the trainings can be held more often and on off shifts.

Within 7 days of receipt of the plan of correction: A designated staff person shall develop and implement a tracking system to ensure all staff persons receive training on all topics specified in 2600.65g during each established training year. Documentation of the tracking system shall be kept. The system shall be reviewed at least quarterly.

3/27/2020  
JM

Legal Entity Representative

Robert Skignaw PCHA

Signature

Roberta S Kraft LAJ PCHA

Printed Name and Title

3/26/2020

Date

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The above plan of correction is approved as of 3/27/2020  
(Date)

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

Plan of correction implementation status as of 4/6/2020  
(Date)

- Implemented
- Not Implemented

81b - Resident Personal Equipment

Regulations

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

There was an uncovered enabler bar present on resident #3's bed, with openings measuring approximately 9.5" horizontally at the top, and 10" vertically to the top of the mattress, posing a potential entrapment hazard.

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.)

Resident #3 bed enabler was in laundry. 2 additional covers were obtained to ensure resident safety when one becomes soiled.  
All staff will educated at the monthly staff meeting on 3/31/2020 to replace cover immediately, and to notify PCHA if cover is in disrepair.  
Second shift is checking bed enabler and cover everyday to prevent entrapment hazard.

Legal Entity Representative

*Roberta Skozyn* PCHA  
Signature

Roberta S Kraft, LCN PC administrator 3/16/20  
Printed Name and Title Date

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(Initials)

Implemented  
 Not Implemented

85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 10:40 am, there was an uncovered trash can, containing a small amount of trash, in the common bathtub room in the Spring Breeze hallway.

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.)

Trash can in tub room on spring breeze hallway was not covered and had a small amount of trash in the can. On 2/21/2020 a new covered trash can was purchased and placed in the spring breeze tub room.

daily ~~at~~ 3/27/2020  
Staff monitors to ensure that trash can is covered. See attached tracker (attachment #3)

If covered can is not present staff will notify PC administrator immediately so that it may be replaced.

\*\*\*Note Shower room on Rosewood Way is under construction and not being utilized for resident care

Legal Entity Representative

*Roberta S Kraft* PCMA  
Signature

Roberta S Kraft CAJ PCMA 3/26/2020  
Printed Name and Title Date

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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

The first aid kit in the medication room does not include eye coverings, tweezers, scissors or a thermometer.

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.)

On 2/21/2020 the first aid kit was relocated to the shelves in the nurses station and labeled in a way to be seen in an emergency and missing items were added.  
 PCHA or nurses will check weekly to ensure all items are located in the kit. Missing items will be replaced ASAP.  
 All PC staff will be educated on the location of the first aid kit at staff meeting on 3/31/2020.

Legal Entity Representative

*Robert Kigron* PCHA  
 Signature

*Roberta S Kraft LSN PC administrator* 3/16/20  
 Printed Name and Title Date

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 (Date) (Date)  
 The above plan of correction was approved by *RM*  Implemented  
 (Initials)  Not Implemented

101j7 - Lighting/Operable Lamp

Regulations

2600.

101.j. Each resident shall have the following in the bedroom:

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

There was no operable lamp or other source of lighting that could be turned on/off at resident #1's bedside.

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.)

Resident #1 is confused and moves her lamp from bedside. Resident was supplied a dimmer tap switch to operate her light from her bedside. Resident can now turn her light on/off from bedside. All PC staff will be educated on use of dimmer on/off switch at next monthly staff meeting on 3/31/2020.

Nurse to check functionality of switch daily and will notify PCHA if missing/not working so a replacement can be obtained.

Legal Entity Representative

Robertas Kraft PCHA  
Signature

Robertas Kraft, LPN PC administrator 3/16/20  
Printed Name and Title Date

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123b - Emergency Procedures Posted

Regulations

2600.

123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

The home's emergency procedures were not posted in a conspicuous and public place 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.)

Emergency procedures were not posted in a public place.

Emergency proceduces (emergency operation plan) was behind the administrative assistants desk.

The emergency operation plan was placed on table next to the visitor sign in log located in the visitor entrance prior to DHS exit on 2/20/2020. (See attachment #4)

Immediately: A designated staff person shall inspect the home monthly to ensure the home's emergency procedures are posted in a conspicuous and public place in the home. *LM* 3/27/2020

Legal Entity Representative

*Robert Skreft* PCAA  
Signature

*Roberta Skreft LPA PCAA* 3/26/2020  
Printed Name and Title Date

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132c - Fire Drill Records

Regulations

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 fire drill record for the fire drill conducted on 9/2/19 at 1:43 pm, indicates "under 4 minutes" for the evacuation time, and does not indicate the exact time of the evacuation in minutes and seconds.

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 fire drill record for 9/2/2019 at 1:43 pm indicated "under 4 minutes" for evacuation time.

The reason why it was not documented in actual minutes and seconds because it was an actual alarm and staff had building evacuated prior to maintenance director arriving on the scene. See attached after action plan (see attachment #5)

Maintenance director educated on the importance of documenting evacuation time correctly for the safety of the residents on 2/20/2020. (see attachment # 6)

Immediately: A designated staff person shall review the home's fire drill records monthly to ensure all items specified in 2600.132c are present on the fire drill records.

*LM* 3/27/2020

Legal Entity Representative

*Robert Skogstvedt (LA) PCMA*

Signature

Roberta S Kraft (LA) PCMA

Printed Name and Title

3/26/2020

Date

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 Not Implemented

184a - Labeling OTC/CAM

Regulations

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #3 is prescribed Albuterol-Ipratropium-3ml every 4 hours via nebulizer as needed for wheezing; however, the pharmacy label indicates-Albuterol-Ipratropium-3 mg/3 ml-In applesauce via nebulizer every 4 hours as needed for wheezing.

Resident #3 is prescribed Novolog 100u/ml-Inject subcutaneously 6 units daily and 3 times daily at 6:00 am, 11:00 am, and bedtime with sliding scale; however, the pharmacy label does not include the sliding scale instructions.

REPEAT VIOLATION: 4/11/2019

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.)

Resident #3 Albuterol-Ipratropium was mislabeled with the directions stating "in applesauce". Vantage Care Apothecary uses their own abbreviations. The abbreviation 1A is 1 ampule which is an appropriate quantity. IA is "in applesauce". PCHA notified Vantage Care of the error and the medication was replaced with a new supply labeled correctly at no cost to the resident. (see attachment #7)

Resident #3 Novolog which was prescribed with a sliding scale was not labeled with directions. Novolog is dispensed from VA Medical Center. PCHA has contacted VA Medical Center regarding placing label with instruction label.

PC staff was educated on the importance of the 5 medication rights to maintain resident safety.

Immediately, then monthly thereafter: A designated staff person shall review the pharmacy labels for all current residents to ensure accuracy in accordance with the prescriber's orders. 3/27/2020

*LM*

Legal Entity Representative

*Roberta Skraft* PCHA  
Signature

*Roberta Skraft LAN PCHA* 3/26/2020  
Printed Name and Title Date

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185b - Medication Procedures

Regulations

2600.

185.b. At a minimum, the procedures must include:

- 2. A process to investigate and account for missing medications and medication errors.

Description of Violation

The home's procedures for the safe use of medications and medical equipment do not include a process to investigate and account for missing medications and medication errors. On 1/23/20, direct care staff persons B and C counted a pharmacy delivery of 60 Lyrica capsules belonging to resident #4. On 1/24/20, direct care staff persons B and D completed a narcotics count during shift change and counted 55 Lyrica capsules belonging to resident #4; however, the resident's controlled substance record indicates that 0 capsules were administered to the resident between 1/23/20 and 1/24/20.

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 B was terminated on 2/24/20. *JM* 3/27/2020

The home's procedures for safe use of medications and equipment does not include a process to investigate and account for missing and medication errors.

This occurrence occurring between 1/23 and 1/24 occurred shortly after PCHA started.

Investigation was led by DON as nurses involved were under his direct supervision.

During staff meeting on 1/28/2020 nurses were educated on policy for when accepting a controlled substances from an outside pharmacy the package must be opened with 2 nurses on delivery and co-signing in the controlled substance record (See attachment #7) A new procedure for medication discrepancy was formulated and put into place. (See attachment #8) Also during staff meeting reviewed the policy on medication ordering and documenting receipt of medications (See attachment #9)

Immediately: A designated staff person shall review all narcotic count sheets monthly for accuracy and completion. *JM* 3/27/2020

Legal Entity Representative

*Roberta Skraft* PCHA  
Signature

Roberta Skraft LCN PCHA 3/26/2020  
Printed Name and Title Date

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(Initials)

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- Implemented
- Not Implemented

187d - Follow Prescriber's Orders

Regulations

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

Description of Violation

Resident #3 is prescribed Novolog 100u/ml-Inject subcutaneously 6 units daily and 3 times daily at 6:00 am, 11:00 am, and bedtime with sliding scale. However, the resident's 11:00 am blood sugar reading on 2/14/20 was not tested until 1:42 pm.

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.)

Resident #3 is prescribed Novolog sq 6 units daily at 6am, 11am and at bedtime daily, with sliding scale however on 2/14/2020 resident's 11am blood sugar reading was not tested until 1:42pm.

Resident #3 was out at an appointment at the Hamot Heart Institute and did not return to the community until 1:30pm. His blood sugar was tested prior to his lunch being served upon his return.

Dr. Jageman resident's PCP was contacted to get order changed to "prior to breakfast, lunch and HS" Therefore blood sugars would only be required 1/2 hour prior to meals and bedtime.

Legal Entity Representative

*Robertas Kraft*

Signature

*Robertas Kraft LAJ PCHA 3/26/2020*

Printed Name and Title

Date

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227g -Support Plan Signatures

Regulations

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

The initial support plan for resident #2, dated 10/31/19, is signed by the resident; however, does not indicate the date the support plan was signed.

The most recent support plan for resident #3, dated 3/28/19, is signed by the resident; however, does not indicate the date the support plan was signed.

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.)

Current PCHA recently started in new role and was in the process of reviewing current support plans.

Resident #2 and #3 service plans will be updated with signatures and dates prior to 4/15/2020.

All service plans will be double checked for all necessary resident signatures and dates.

Legal Entity Representative

Robert Skraft, RN PCHA  
Signature

Roberta S Kraft, RN PC administrator 3/16/20  
Printed Name and Title Date

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Implemented  
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