

Department of Human Services
Bureau of Human Service Licensing

August 6, 2021

██████████ CEO
SARAH A REED RETIREMENT CENTER
227 WEST 22ND STREET
ERIE, PA 16502

RE: SARAH REED SENIOR LIVING
227 WEST 22ND STREET
ERIE, PA, 16502
LICENSE/COC#: 44761

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/12/2021, 04/22/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Suzy Quinn

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: SARAH REED SENIOR LIVING **Licen e #:** 44761 **Licen e Expiration Date:** 06/16/2021
Addr e : 227 WEST 22ND STREET, ERIE, PA 16502
County: ERIE **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** 8148782600 **Email:** [REDACTED]

Legal Entity

Name: SARAH A REED RETIREMENT CENTER
Address: 227 WEST 22ND STREET, ERIE, PA, 16502
Phone: 8148782600 **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 10/11/1994 **Issued By:** Labor & Industry

Staffing Hours

Re ident Support Staff: 0 **Total Daily Staff:** 81 **Waking Staff:** 61

Inspection

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Incident **Exit Conference Date:** 05/17/2021

Inspection Dates and Department Representative

04/12/2021 - On-Site: [REDACTED]
04/22/2021 - Off-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 100 **Residents Served:** 65

Secured Dementia Care Unit

In Home: Yes **Area:** Zurn Pavilion **Capacity:** 25 **Residents Served:** 16

Hospice

Current Re ident : 1

Number of Residents Who:

Receive Supplemental Security Income: 1 **Are 60 Years of Age or Older:** 62
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 16 **Have Physical Disability:** 0

Inspections / Reviews

04/12/2021 - Partial

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*Follow-Up Date: *06/12/2021*

6/9/2021 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *06/16/2021*

7/9/2021 - POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*Follow-Up Date: *07/16/2021*

8/6/2021 - Document Submission

Lead 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 4/5/21 at 5:59 PM, staff person A reported to work intoxicated. Sometime between 6:30 PM - 9:00 PM, an altercation between staff person A and resident #1 occurred in resident #1's bedroom while staff person A was assisting resident #1 with toileting.

On [REDACTED] at approximately 9:00 PM, staff person B entered resident #1's bedroom to administer medication and found the resident laying in bed, [REDACTED] wheeled walker was in the living room and [REDACTED] wheelchair was near the window. [REDACTED] oxygen nasal cannula was off and was pulled through the back of [REDACTED] pajama shirt. There was blood on [REDACTED] pillow, bedsheets and 2 spots of blood were on the carpet near the closet. Resident #1 told staff person B [REDACTED] was pushed up against the wall by [REDACTED] aide, who was upset with [REDACTED] for taking too long on the toilet. Staff person C came in to assist and both staff observed a large, deep skin tear on [REDACTED] left arm around [REDACTED] elbow with bruising above and below it, smaller half-moon shaped skin tears on both forearms, [REDACTED] right leg was rotated out and [REDACTED] complained of pain. Staff person B and staff person C called staff person D, a nurse, to assess the resident and assist with the skin tear because it was too deep. Staff person D applied steri-strips to the skin tear. Staff person E entered the bedroom and observed resident 1 having trouble breathing. Staff had difficulty removing the oxygen tubing from the resident's pajama shirt and put new tubing on [REDACTED] portable tank so [REDACTED] could get oxygen immediately. Resident #1 was transported via emergency services to the hospital, where [REDACTED] reported to hospital staff that [REDACTED] caretaker was frustrated with [REDACTED] and threw [REDACTED] into the bathroom wall. Resident #1 was admitted to the hospital and was diagnosed with a possible subtle right hip fracture, contusion on [REDACTED] right thigh and a skin tear on [REDACTED] left elbow. However, this allegation of abuse was not reported to the local Area Agency on Aging until 4/6/21 at 3 PM, after the hospital reported the allegation of abuse to APS and APS contacted the home.

15a - Resident Abuse Report (continued)

Plan of Correction

Directed

On April 6, 2021, Administrator was notified by APS that Resident 1 made a claim of abuse to hospital personnel. On April 6, 2021, Administrator began an investigation in abuse claim of Resident 1 and interviewed staff who had had direct contact with Resident on April 5, 2021. On April 9, 2021, Staff Member A was terminated after information was obtained from a staff member that [REDACTED] had reported to work intoxicated. By June 30, 2021, all staff working in personal care will be re-educated regarding the current abuse policy and the obligation of staff to report suspected abuse within 2 hours of forming suspicion if serious bodily injury occurs to a resident or within 24 hours of forming a suspicion if serious bodily injury does not occur. Verification of this re-education will be submitted to DHS no later than July 1, 2021. Beginning 6/15/21, Administrator will educate new hires into personal care department on abuse policy and responsibilities of reporting abuse. Verification of this education will be maintained in personnel file.

Directed-

Staff re-education shall include the following:

- Immediately report suspected abuse of a resident served in the home in accordance with the Older Adults Protective Services Act (35 P.S. Sections 10225.101 – 10225.5102) and 6 Pa. Code Sections 15.21 – 15.27.
- If the report involves a staff person, the home must immediately suspend the staff person involved in the alleged abuse or place the staff person on a plan of supervision in accordance with §2600.15(b). The home shall immediately submit to the Department a plan of supervision or notice of suspension of the affected staff person in accordance with §2600.15(c).
- The home shall immediately notify the resident and the resident’s designated person of a report of suspected abuse or neglect involving the resident, in accordance with §2600.15(d).
- Report the abuse allegation to the Department in accordance with §2600.16.
- Begin an internal investigation of the abuse in accordance with §2600.44 unless otherwise directed by the Department.

S.Q. 7/9/21

Within 48 hours of receipt and weekly thereafter, the administrator shall review all incidents and conditions and interview 6 residents and staff to ensure any allegations of abuse are reported in accordance with §2600.15 and §2600.16.

S.Q. 7/9/21

Completion Date: 06/30/2021

Document Submission

Implemented

Monitoring documents submitted.

42b - Abuse

1. 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.

42b - Abuse (continued)

Description of Violation

Resident #1's most recent assessment and support plan, dated 2/17/21, indicates ■■■ needs assistance with ambulating, uses a wheeled walker and wheelchair to ambulate, and needs assistance with toileting and transfers. ■■■ has acute respiratory failure with hypoxia and is prescribed oxygen.

On 4/5/21 at 5:59 PM, staff person A reported to work intoxicated. Sometime between 6:30 PM - 9:00 PM, an altercation between staff person A and resident #1 occurred in resident #1's bedroom while staff person A was assisting resident #1 with toileting.

On ■■■ at approximately 9:00 PM, staff person B entered resident #1's bedroom to administer medication and found the resident laying in bed, ■■■ wheeled walker was in the living room and ■■■ wheelchair was near the window. ■■■ oxygen nasal cannula was off and was pulled through the back of ■■■ pajama shirt. There was blood on ■■■ pillow, bedsheets and 2 spots of blood were on the carpet near the closet. Resident #1 told staff person B ■■■ was pushed up against the wall by ■■■ aide, who was upset with ■■■ for taking too long on the toilet. Staff person C came in to assist and both staff observed a large, deep skin tear on ■■■ left arm around ■■■ elbow with bruising above and below it, smaller half-moon shaped skin tears on both forearms, ■■■ right leg was rotated out and ■■■ complained of pain. Staff person B and staff person C called staff person D, a nurse, to assess the resident and assist with the skin tear because it was too deep. Staff person D applied steri-strips to the skin tear. Staff person E entered the bedroom and observed resident 1 having trouble breathing. Staff had difficulty removing the oxygen tubing from the resident's pajama shirt and put new tubing on ■■■ portable tank so ■■■ could get oxygen immediately. Resident #1 was transported via emergency services to the hospital, where ■■■ reported to hospital staff that ■■■ caretaker was frustrated with ■■■ and threw ■■■ into the bathroom wall. Resident #1 was admitted to the hospital and was diagnosed with a possible subtle right hip fracture, contusion on ■■■ right thigh and a skin tear on ■■■ left elbow. On ■■■ ■■■ was discharged to a skilled nursing facility. Staff person A was charged with neglect of care-dependent person and simple assault by the local police department.

42b - Abuse (continued)

Plan of Correction

Directed

Staff Person A was terminated on [REDACTED] after completion of abuse investigation. Staff will be re-educated that a resident may never be neglected, intimidated, physically or verbally abused, mistreated, or subjected to corporal punishment or disciplined in any way. Immediate termination will occur if staff does not follow this policy. Staff will sign an acknowledgement stating the above and this will be kept in their personnel file. Verification of this training will be sent to DHS by July 1,2021.

Directed:

Within 48 hours of receipt, the administrator shall implement procedures that ensure compliance with §2600.42(b). The procedures shall include administrator or designee interviews with at least 6 residents privately regarding care and treatment, weekly for 2 months and then at least monthly thereafter. Documentation of the interviews shall be kept and reviewed at quality management plan reviews.

S.Q. 7/9/21

Within 5 days of receipt, the administrator shall develop and implement policy and procedures to ensure all direct care staff are free from a medical condition, including drug or alcohol addiction, that would limit them from providing necessary personal care services with reasonable skill and safety in accordance with §2600.54(a).

S.Q. 7/9/21

During the next quality management plan review and evaluation, the home shall place an increased emphasis on these plans of correction and take action to improve the quality of its resident rights training for all newly hired staff within 40 scheduled working hours in accordance with §2600.65(b)(1) and annually in accordance with §2600.65(g) (3).

S.Q. 7/9/21

Completion Date: 07/01/2021

Document Submission

Implemented

Monitoring documents submitted