

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

February 18, 2023

[REDACTED]
MILLCREEK MANOR
322 WASHINGTON PLACE
ERIE, PA, 16505

RE: REGENCY SUITES/REGENCY AT
SOUTH SHORE
322 WASHINGTON PLACE
ERIE, PA, 16505
LICENSE/COC#: 44657

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/04/2022, 10/05/2022, 10/06/2022 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]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: REGENCY SUITES/REGENCY AT SOUTH SHORE **License #:** 44657 **License Expiration:** 11/03/2023
Address: 322 WASHINGTON PLACE, ERIE, PA 16505
County: ERIE **Region:** WESTERN

Administrator

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

Legal Entity

Name: MILLCREEK MANOR
Address: 322 WASHINGTON PLACE, ERIE, PA, 16505
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 2 LP **Date:** 04/08/1993 **Issued By:** PA Dept. L & I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 75 **Waking Staff:** 56

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 10/06/2022

Inspection Dates and Department Representative

10/04/2022 On Site [REDACTED]
 10/05/2022 On Site [REDACTED]
 10/06/2022 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 70 **Residents Served:** 63

Secured Dementia Care Unit

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

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 62
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 12 **Have Physical Disability:** 3

Inspections / Reviews

10/04/2022 - Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 10/30/2022

Inspections / Reviews (*continued*)

12/16/2022 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 12/23/2022

02/04/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 02/11/2023

02/18/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 02/16/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

On 10/4/22, the outlet powered carbon monoxide detectors in the 3rd floor south and north air handler rooms were plugged into the wall within 5ft of the fossil fuel burning air handlers.

Plan of Correction

Accept [redacted] - 02/04/2023)

Carbon Monoxide detectors were corrected on 10/4/2022 at the time of inspection and inspector approved. Corrections were made by Maintenance Director, Chris Hall. All other devices were inspected on 10/4/22 by Chris Hall, Maintenance Director and met regulatory compliance.

Any new Carbon Monoxide detectors placed will not be placed within 5ft. of fossil fuel burning air handlers.

Licensee's Proposed Overall Completion Date: 12/16/2022

Implemented [redacted] - 02/18/2023)

25b - Contract Signatures

2. Requirements

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract dated [redacted] 22 for resident #1 does not include the date the resident signed the contract.

Repeat Violation: 7/19/21

Plan of Correction

Accept [redacted] - 02/04/2023)

The signature date was added on [redacted]/22 by the resident. Administrator completed a full file audit on 11/9/2022.

Any resident with a missing signature signed addendum at the time of discovery unless already discharged.

Addendums can be found attached to contract. Administrator will audit monthly all new move ins to verify signatures are completed.

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented [redacted] 02/18/2023)

66b - Training Plan Content

3. Requirements

2600.

66b - Training Plan Content *(continued)*

66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:

Description of Violation

On 10/5/22, the home did not have an annual training plan for training year 1/1/22 to 12/31/22.

Plan of Correction

Accept (████ - 02/04/2023)

Administrator developed new training calendar for remaining 2022 and 2023 year. This was completed 10/28/2022. All trainings will meet the requirements of the department. Any additions or changes will be noted on training calendar.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented (████ - 02/18/2023)

82a Poisonous Materials

4. Requirements

2600.

82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

On 10/4/22 at 10:30 a.m., there was an unlabeled 2-gallon spray bottle in the 1st floor housekeeping supply room, containing a clear liquid identified by the maintenance director as Single Pass Extraction Floor cleaner. The original product labeling indicates to immediately contact a poison center/doctor if swallowed.

Plan of Correction

Accept (████ 02/04/2023)

Unlabeled 2-gallon spray bottle corrected on 10/4/2022 by housekeeping supervisor, █████. Pictures attached. On 10/28/22, Housekeeping Supervisor trained all housekeepers on poisonous material handling. Monthly audits are completed by housekeeping supervisor and audit began October 2022.

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented (████ - 02/18/2023)

92 Windows

5. Requirements

2600.

92. Windows and Screens Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

On 10/4/22, there were no screens in the northwest and northeast 1st, 2nd, and 3rd floor stairwell windows.

Plan of Correction

Accept (████ 02/04/2023)

All screens but three were installed 10/4/22. The remaining three were ordered and installed on 11/15/22 by █████ Maint. Director. Monthly audit started November 2022 by Maint. Director Chris Hall. Audit record kept in state binder and an extra screen was ordered for back up.

92 - Windows (continued)

A monthly audit will be completed to make sure all screens are inserted and in good repair. Attached is auditing tool that will be used.

Licensee's Proposed Overall Completion Date: 12/19/2022

Implemented [REDACTED] 02/18/2023)

103i Outdated Food

6. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 10/4/22 at 10:05 a.m., a 3/4 full 5 pound bag of flour with a best by date of 5/28/18, and a 3/4 full 1 liter bottle of white vinegar with a best by date of 9/11/16, were on the top shelf of the kitchenette cabinet in the 1st floor hobby room.

Plan of Correction

Accept [REDACTED] - 02/04/2023)

Flour and vinegar were removed 10/4/2022. A weekly audit calendar was placed in the Hobby Shop 10/27/2022 by administrator and checked by administrator and activities coordinator. On 10/27/22 a weekly audit calendar was placed in personal care dining room and will be checked by resident aides and administrator.

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented [REDACTED] - 02/18/2023)

131f Fire E tinguisher Inspection

7. Requirements

2600.

131.f. Fire e tinguishers shall be inspected and approved annually by a fire safety e pert. The date of the inspection shall be on the extinguisher.

Description of Violation

On 10/4/22, the fire extinguishers in the 2nd and 3rd floor laundry rooms on the south end of the home had not been inspected by a fire safety expert since June 2021.

Plan of Correction

Accept [REDACTED] 02/04/2023)

See attached.

In order to maintain compliance moving forward with 2600.131.f. a new Fire Extinguisher check off list was created by administrator [REDACTED]. The practice began October 26th, 2022. Monthly audit is completed by Chris Hall, Maint. Director. This audit includes not only gauge check but tag check as well to verify all extinguishers are inspected within the correct time frame.

The two fire extinguishers were inspected October 26th and new tags were placed on extinguishers by Fire Line Group.

The two fire extinguishers noted were inspected and the correct tag was attached immediately prior to completion

131f - Fire Extinguisher Inspection (continued)

of annual inspection which inspector reviewed.

Licensee's Proposed Overall Completion Date: 12/19/2022

Implemented [REDACTED] - 02/18/2023)

132a - Monthly Fire Drill

8. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of January 2022.

Plan of Correction

Accept [REDACTED] - 02/04/2023)

All fire drills should be completed no later than 3 days prior to ending of the month in the event Maintenance Director is unable to complete due to absence from facility. If in the event facility Maintenance Director is not available, Community Director will communicate with Physical Plant Manager to schedule a time for the drill to be completed to within month.

[REDACTED] Maint. Director began October 24th conducting fire drill 3 days prior to the end of the month. In the even [REDACTED], Maint. Director cannot complete drill, substitute Maint. Director [REDACTED] will be notified.

Licensee's Proposed Overall Completion Date: 12/19/2022

Implemented [REDACTED] - 02/18/2023)

132d - Evacuation

9. Requirements

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's fire drill record indicates not all residents in the home at the time of the drill were evacuated during the following drills:

- On 2/9/22, 90 residents were present; however, 55 residents evacuated.
- On 2/28/22, 92 residents were present; however, 57 residents evacuated.
- On 3/29/22, 95 residents were present; however, 59 residents evacuated.
- On 4/29/22, 96 residents were present; however, 59 residents evacuated.
- On 5/2/22, 96 residents were present; however, 59 residents evacuated.
- On 6/28/22, 101 residents were present; however, 61 residents evacuated.
- On 7/28/22, 103 residents were present; however, 62 residents evacuated.
- On 8/31/22, 101 residents were present; however, 60 residents evacuated.
- On 9/29/22, 106 residents were present; however, 61 residents evacuated.

Plan of Correction

Accept [REDACTED] - 02/04/2023)

Adult Licensing Fire Drill Log will not include the independent residents in "residents present". Fire Drill Log will

132d - Evacuation (continued)

only list those residents under personal care status. Facility will continue to have independent residents participate.

Attached is October 2022 Fire Drill Log with correct documentation.

██████████, Maint. Director began October 24th correct documentation of fire drills and correct number of residents not including independent residents. ██████████ will only document PC Residents effective October 24th and will continue this moving forward each month.

Licensee's Proposed Overall Completion Date: 12/19/2022

Implemented ██████████ - 02/18/2023)

171b5 - First Aid Kit

10. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

On 10/4/22 at 12:30 p.m., the first aid kit in the 350 Ford Transit Van used to transport residents did not include an antiseptic.

On 10/4/22 at 1:30 p.m., the first aid kit in the Ford Transit connect minivan used to transport residents did not include an antiseptic.

Plan of Correction

Accept (██████████) - 02/04/2023)

New first aid kits were purchased on 10/4/28 by transportation director and immediately placed in vans. New kits were placed in the van and contain all items listed in Ch. 2600 Regulation Compliance Guide. Transportation Director started monthly audit 10/28/22 to ensure all items are accessible in vehicles.

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented ██████████ - 02/18/2023)

184a - Resident's Meds Labeled

11. Requirements

2600.

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

4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribed ██████████ by mouth every 3 hours as needed for ██████████ however, the pharmacy label indicates every 3-4 hours as needed.

184a - Resident's Meds Labeled (continued)

Plan of Correction

Accept (SQ 02/04/2023)

Resident #2 was corrected [redacted]/2022 with "directions changed refer to physicians order" sticker placed on label by [redacted] Nursing Supervisor. [redacted] Nurse also notified and nursing supervisor asked for label to be changed to reflect what MAR states.

MAR and cart audits began 11/25/2022 of all four medication carts by LPN, [redacted] and medication techs. Cart audits are occurring weekly and have been completed 11/25/22, 12/1/22, 12/7/22, 12/13/22. These audits will continue weekly or as needed. Staff will verify labels match MAR and that all medications are present.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented [redacted] - 02/18/2023)

187b - Date/Time of Medication Admin.

12. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #4 is prescribed [redacted] delayed release 81mg tablet - Take by mouth in the afternoon, and [redacted] 100mg capsule - Take by mouth in the afternoon; however, resident #4's September 2022 medication administration record does not include the initials of the staff person who administered these medications on [redacted]/22 at [redacted] p.m.

Plan of Correction

Accept [redacted] 02/04/2023)

DON began audit to review MARS for missing signatures on 10/28/2022.to review MARS for missing signatures weekly. Medication Techs educated to review MAR at the end of each shift and identify missing signatures. Medication Technicians educated on 10/5/2022 by nursing supervisor [redacted], LPN.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented [redacted] - 02/18/2023)

224a - Preadmission Screen Form

13. 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 #4's preadmission screening form, dated [redacted] 22, 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 ([redacted] 02/04/2023)

Resident #4 pre-admission screen was finalized and completed on [redacted] 2022 by PCHA, [redacted]. An audit of all pre-admission screens was completed 11/10/22 by Director of Nursing, [redacted] and again on 12/12/22 by [redacted], PCHA. An audit verified all boxes have been checked appropriately. All pre-admission screens should be reviewed and completed by nursing supervisor or administrator. All new admissions will be reviewed at

224a - Preadmission Screen Form (continued)

month end QA meeting to verify completion.

Resident #4's preadmission screen has been finalized with all necessary required documentation.

Licensee's Proposed Overall Completion Date: 12/20/2022

Implemented [REDACTED] - 02/18/2023)

225c - Additional Assessment

14. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #3's assessment, dated [REDACTED] 22, does not indicate the resident's need for the assistive enabler bar installed on the resident's bed.

Repeat violation: 7/19/21

Plan of Correction

Accept [REDACTED] - 02/04/2023)

Resident #3's RASP was updated [REDACTED]/2022 and given to inspector. Additional audit was completed by Nursing Supervisor, [REDACTED] on 11/11/22. In order to maintain compliance quarterly audits will be completed by nursing supervisor and regular care plan meetings will be held with family and residents to identify any changes regarding assisted devices.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented [REDACTED] - 02/18/2023)

227d - Support Plan Medical/Dental

15. Requirements

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2 receives [REDACTED]; however, the resident's support plan, dated [REDACTED] 22, does not indicate the services being provided [REDACTED]

Plan of Correction

Accept [REDACTED] - 02/04/2023)

Audit was conducted 11/5/2022 by [REDACTED], Nursing Supervisor, verifying all residents receiving outside services were appropriately listed in RASP. Resident # 2's RASP was updated [REDACTED]/2022 and given to surveyor during inspection.

227d - Support Plan Medical/Dental (continued)

Another recent audit was completed 12/12/22 by administrator, [REDACTED] and updates completed by nurse.

Licensee's Proposed Overall Completion Date: 12/21/2022

Implemented [REDACTED] 02/18/2023)