pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: MAY 24, 2023

[redacted]
Millcreek Manor
[redacted]

RE: Lecom Parkside at Glenwood
41 West Gore Road
Erie, PA 16509
License/COC #: 453841

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on November 15, 2022, December 14, 2022, and January 31, 2023 of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 45384) dated October 1, 2022, to October 1, 2023, and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your directed plans to correct the violations as specified on the LIS. The license dated October 1, 2022, to October 1, 2023, is NOT reinstated upon expiration of this FIRST PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1); (5) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from May 24, 2023 to November 24, 2023.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *LECOM PARKSIDE AT GLENWOOD* **License #:** *45384* **License Expiration:** *10/01/2023*

Address: *41 WEST GORE ROAD, ERIE, PA 16509*

County: *ERIE* **Region:** *WESTERN*

Administrator

Name: [redacted] **Phone:** [redacted] **Email:** [redacted]

Legal Entity

Name: *MILLCREEK MANOR*

Address: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *09/19/2002* **Issued By:** *Dept. of Labor & Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *82* **Waking Staff:** *62*

Inspection Information

Type: *Partial* **Notice:** *Unannounced* **BHA Docket #:**

Reason: *Incident* **Exit Conference Date:** *12/06/2022*

Inspection Dates and Department Representative

11/15/2022 - On-Site: [redacted]

12/14/2022 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served:** *63*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Second Floor* **Capacity:** *16* **Residents Served:** *14*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *8* **Are 60 Years of Age or Older:** *63*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

11/15/2022 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/09/2023*

01/31/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/07/2023*

02/17/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *02/24/2023*

05/17/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *04/03/2023*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/15/22, resident #1 called crisis services because he was having thoughts of hurting [redacted] and others and stabbing [redacted] in the chest. Local police and EMS arrived at the home at approximately 1:15pm and transported the resident to the hospital for evaluation. However, the home did not report this incident to the Department until 10/17/22 at 12:50pm.

Plan of Correction ***Directed [redacted] - 02/17/2023)***

ED educated all staff at the clinical staff meeting on 1/5/23 that all incident reports must be completed and reported to DHS within 24hours of incidents. All incident reports will be kept in a binder in ED office beginning 10/1/22. The ED or designee will monitor the incident reports daily, ensuring they are completed timely utilizing the attached log sheet.

Directed:

Per the administrator, monitoring began 2/14/23.

Directed Completion Date: *02/14/2023*

Not Implemented [redacted] - 05/17/2023)

42b - Abuse

2. 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.

Description of Violation

Resident #1, admitted [redacted] is diagnosed with schizophrenia, anxiety, and bipolar disorder, and is prescribed Clonazepam 0.5mg 3 times a day for anxiety control. However, the home failed to administer 90 doses of this medication from 8/17/22 – 9/19/22 because their attending physician did not review and approve the medication until 8/22/22 and when the medication ran out, the home failed to refill the prescription until 9/19/22. The FDA box warning label indicates that the abrupt discontinuation or rapid dosage reduction of Clonazepam after continued use may precipitate acute withdrawal reactions, which can be life-threatening.

42b - Abuse (continued)

On 8/31/22 resident #1 called crisis services, stating [redacted] was feeling depressed and having thoughts of hurting [redacted] and others. Crisis services arrived at the home, spoke to the resident, staff, and the resident's blended case manager. Resident #1 was transported to Millcreek Community Hospital for further evaluation. The emergency department's behavioral health evaluation indicates he presented with complaints of depression and suicidal ideation for the past 4 days. Resident #1 said [redacted] planned to take a knife and stab [redacted] and described having homicidal ideations specifically towards [redacted], stating [redacted] would shoot [redacted] despite being aware that [redacted] is deceased. The home failed to inform crisis services or Millcreek Community Hospital that the resident was not administered Clonazepam for anxiety control since 8/16/22. Resident #1 was discharged back to the home where he was to be monitored and supervised.

Plan of Correction ***Directed [redacted] - 02/17/2023)***

On 1/6/23 all new admissions orders are to be obtained within 24 hours of admission. If resident is a [redacted] resident the orders will be faxed to Millcreek Manor pharmacy immediately for same day delivery. ED, DON, ADON will call/[redacted] office assistant to ensure orders are obtained on admission. ED, DON, ADON will request the DME and list of orders while doing admission eval on all residents who do not have Dr. Lin as PCP. ED, DON, ADON will contact PCP twice daily until orders are received. [redacted] came to Parkside at Glenwood on 12/9/2022 to discuss LECOM behavioral health services and education available to residents and staff.[redacted] is scheduled to discuss "Understanding the Psychiatric Issues in Dementia" at the May 4,2023 where[redacted] will discuss the importance of consistent dosing. Any medications that are due for a refill are processed automatically when the nurse/med tech clicks on reorder in PCC. DON to review all new admissions within in 24 hours of admission to confirm that the medications are available. Cart audits are then done monthly and PRN by the 3rd shift med tech

Directed:
Per the administrator, if resident is a [redacted] resident the orders will be faxed to Millcreek Manor pharmacy immediately for same day delivery by the ADON or DON.

Directed:
Per the administrator, beginning 2/6/23, any medications that are due for a refill are processed automatically when the nurse/med tech clicks on reorder in PCC.

Directed:
Per the administrator, beginning 2/6/23, the DON reviews all new admissions within in 24 hours of admission to confirm that the medications are available.

Directed:
Per the administrator,
Monthly cart audits have been ongoing, and the last audit was conducted on 1/17/23.

Directed Completion Date: *02/14/2023*

Not Implemented [redacted] - 05/17/2023)

187d - Follow Prescriber's Orders

3. Requirements

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

187d - Follow Prescriber's Orders *(continued)*

Description of Violation

Resident #1, admitted [redacted] is diagnosed with schizophrenia, anxiety, and bipolar disorder, and is prescribed Clonazepam 0.5mg 3 times a day for anxiety control. However, the home failed to administer 90 doses of this medication from 8/17/22 – 9/19/22 because their attending physician did not review and approve the medication until 8/22/22 and when the medication ran out, the home failed to refill the prescription until 9/19/22. The FDA box warning label indicates that the abrupt discontinuation or rapid dosage reduction of Clonazepam after continued use may precipitate acute withdrawal reactions, which can be life-threatening.

On 8/31/22 resident #1 called crisis services, stating [redacted] was feeling depressed and having thoughts of hurting [redacted] and others. Crisis services arrived at the home, spoke to the resident, staff, and the resident's blended case manager. Resident #1 was transported to Millcreek Community Hospital for further evaluation. The emergency department's behavioral health evaluation indicates he presented with complaints of depression and suicidal ideation for the past 4 days. Resident #1 said [redacted] planned to take a knife and stab [redacted] and described having homicidal ideations specifically towards [redacted], stating [redacted] would shoot [redacted] despite being aware that [redacted] is deceased. The home failed to inform crisis services or Millcreek Community Hospital that the resident was not administered Clonazepam for anxiety control since 8/16/22. Resident #1 was discharged back to the home where he was to be monitored and supervised.

Resident #1 is also prescribed the below medications; however, the home did not administer these medications to the resident from 8/17/22 to 8/22/22 because their attending physician did not review and approve the medications until 8/22/22:

* *Levothyroxine 175mcg 1 daily for Hypothyroidism*
* *Montelukast 10mg 1 daily by mouth for Asthma*
* *Olanzapine 10mg 1 daily for Mental Health conditions*
* *Pantoprazole 40mg 1 daily for Reflux*
* *Polyethylene Glycol 1 cap in 17g water daily for Constipation*
* *Simvastatin 40mg 1 daily for Hyperlipidemia*
* *Therems Mineral Tab 1 daily Multivitamin*
* *Flovent Diskus 250mcg 1 puff by mouth 2x daily for Asthma*
* *Oxybutynin 5mg 1 by mouth 2x daily for Overactive Bladder*
* *Senna 8.6mg 1 by mouth 2x daily for Constipation*

Plan of Correction ***Directed [redacted] - 02/17/2023)***

On 1/6/23 all new admissions orders are to be obtained within 24 hours of admission. If resident is a [redacted] resident the orders will be faxed to Millcreek Manor pharmacy immediately for same day delivery. ED, DON, ADON will call/text [redacted] office assistant to ensure orders are obtained on admission. ED, DON, ADON will request the DME and list of orders while doing admission eval on all residents who do not have [redacted] as PCP. Orders must be obtained within 8 hours of admission. ED, DON, ADON will require the family of new admission residents to obtain prescriptions from their preferred pharmacy and deliver them to the facility. DON or ADON will ensure that all medications are available for administration within 24 hours of admission by conducting a cart audit. The med carts are then audited monthly by 3rd shift med tech.

Directed:

Per the administrator, if resident is a [redacted] resident the orders will be faxed to Millcreek Manor pharmacy immediately for same day delivery by the ADON or DON.

187d - Follow Prescriber's Orders (continued)

Directed:
Per the administrator, beginning 2/6/23, ED, DON, ADON will require the family of new admission residents to obtain prescriptions from their preferred pharmacy and deliver them to the facility.

Directed:
Per the administrator, beginning 2/6/23, the DON or ADON reviews all new admissions within in 24 hours of admission to confirm that the medications are available by conducting a cart audit.

Directed:
Per the administrator, monthly cart audits have been ongoing, and the last audit was conducted on 1/17/23.

Directed Completion Date: *02/14/2023*

Not Implemented [redacted] - 05/17/2023)