



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail to: [REDACTED]

E-mailed on: 1/4/23

[REDACTED], COO
INTEGRACARE ERIE LLC
[REDACTED]

RE: THE RESIDENCE AT PRESQUE ISLE BAY
1012 WEST BAYFRONT PARKWAY
ERIE, PA 16507
LICENSE/COC #: 45350

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on 5/24/23, 5/25/23, and 5/31/23 of the above facility, we have determined that your submitted plan of correction is not fully implemented. Correction of these violations in accordance with the specified plan of correction is required. Continued compliance must be maintained.

Sincerely,

[REDACTED]

Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

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

Facility Information

Name: *THE RESIDENCE AT PRESQUE ISLE BAY* License #: *45350* License Expiration: *03/24/2024*
Address: *1012 WEST BAYFRONT PARKWAY, ERIE, PA 16507*
County: *ERIE* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *INTEGRACARE ERIE LLC*
Address: [REDACTED]
Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *I-2* Date: *09/02/2010* Issued By: *City of Erie*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *74* Waking Staff: *56*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal, Incident* Exit Conference Date: *05/31/2023*

Inspection Dates and Department Representative

05/24/2023 - On-Site: [REDACTED]
05/25/2023 - On-Site: [REDACTED]
05/31/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* Residents Served: *49*

Secured Dementia Care Unit

In Home: *Yes* Area: *1ST FLOOR* Capacity: *22* Residents Served: *16*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *48*
Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *25* Have Physical Disability: *0*

Inspections / Reviews

05/24/2023 - Full

Lead Inspector: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/01/2023*

07/14/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/10/2023*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *07/21/2023*

07/28/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/10/2023*

Reviewer: [REDACTED]

Follow-Up Type: *POC Submission*Follow-Up Date: *08/04/2023*

09/12/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: *11/10/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *09/23/2023*

11/03/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/10/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *11/10/2023*

01/04/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: *11/10/2023*

Reviewer: [REDACTED]

Follow-Up Type: *Exception*

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

Resident #1 and resident #2 reside in the secure dementia care unit (SDCU). Resident #1 is diagnosed with [REDACTED] initial documentation of medical evaluation (DME), dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #1's initial resident assessment and support plan (RASP), dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition. Resident #2 is diagnosed with [REDACTED] initial DME, dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #2's initial RASP, dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition.

In the early morning hours of [REDACTED]/22, staff person A and staff person B found resident #1 and resident #2 [REDACTED] in resident #1's bedroom. Resident #2 [REDACTED] resident #1. However, this incident was not reported to the Area Agency on Aging until 12/27/22.

Plan of Correction

Accept [REDACTED] - 09/12/2023)

Starting 8/11/2023 all reports to AOA (Area Office of Aging) will be submitted by the administrator or designee immediately, for all report allegations of abuse to the Area Office of Aging. This followed up with an email sent to the Executive Operations Director and the AOA (Area Office of Aging) representative noted the details of the phone conversation regarding any suspected reporting. The date, time and phone number called will be in the body of the email and this will be done as soon as all parties are safe and within the first 24 hours. This plan was developed by [REDACTED] Executive Operations Officer and discussed and put into place with [REDACTED] Resident Wellness Director on 8/11/2023. Beginning 8/11/2023 all incidents will be discussed at morning meeting by [REDACTED] Executive Operations Officer or by [REDACTED] Resident Wellness Director. Beginning 8/11/2023 [REDACTED] will monitor a reporting binder weekly to ensure all updated reportable are in file.

Licensee's Proposed Overall Completion Date: 08/17/2023

Not Implemented [REDACTED] - 01/04/2024)

16c - Written Incident Report

2. 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

Resident #1 and resident #2 reside in the SDCU. Resident #1 is diagnosed with [REDACTED] initial DME, dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #1's initial RASP, dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition. Resident #2 is diagnosed with [REDACTED] initial DME, dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #2's initial RASP, dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition.

16c - Written Incident Report (continued)

In the early morning hours of [REDACTED]/22, staff person A and staff person B found resident #1 and resident #2 [REDACTED] in resident #1's bedroom. Resident #2 [REDACTED] resident #1. However, this incident was not reported to the Department.

Plan of Correction

Accept [REDACTED] 09/12/2023)

[REDACTED] Resident Wellness Director will continue to educate staff to do frequent rounds during sleeping hours. The administrator or designee will report reportable incidents and conditions to the Department within 24 hours. [REDACTED] Executive Operations Officer had requested that all state reportable to be emailed to the regional office. Along with this [REDACTED] will be CCed on all reportable to ensure a second set of eyes noted the report starting 8/11/2023 and after all parties are safe and within 24 hours of incident. Training on 5/31/2023 was done by [REDACTED] Executive Operations Officer with [REDACTED] Resident Wellness Director on Pennsylvania State Regulation 2600.16 and our policy community policy on reporting any and all alleged abuse. Beginning 8/11/2023 all incidents will be discussed at morning meeting by [REDACTED] Executive Operations Officer or by [REDACTED] Resident Wellness Director. Beginning 8/11/2023 [REDACTED] will monitor a reporting binder weekly to ensure all updated reportables are in file.

Licensee's Proposed Overall Completion Date: 08/17/2023

Not Implemented [REDACTED] - 01/04/2024)

42b - Abuse

3. 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 and resident #2 reside in the SDCU. Resident #1 is diagnosed with [REDACTED] initial DME, dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #1's initial RASP, dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition. Resident #2 is diagnosed with [REDACTED] initial DME, dated [REDACTED]/22, indicates [REDACTED] has poor cognitive function. Resident #2's initial RASP, dated [REDACTED]/22, indicates [REDACTED] requires extensive supervision, and has a moderate problem with judgment and awareness cognition.

In the early morning hours of [REDACTED]/22, staff person A and staff person B found resident #1 and resident #2 [REDACTED] in resident #1's bedroom. Resident #2 [REDACTED] resident #1.

The home failed to provide adequate supervision to prevent this incident from occurring.

Plan of Correction

Accept [REDACTED] - 09/12/2023)

[REDACTED] Resident Wellness Director will review all schedules prior to posting them to ensure all shifts are staffed in accordance with regulation stated in the 2600.42b regulations discussed and put into place on 8/11/2023 as well as all non-covered call offs will be covered by a member of community's leadership team.

The immediate step performed by staff person A and B was to redirect each resident back to their own rooms. There were 15-minute checks put in place throughout the night and next day. No further contact was noted and neither resident was showing signs or symptoms of trauma. There have been no room changes at this time. There has been

42b - Abuse (continued)

no further contact has been made between the two involved residents.

██████████ Resident Wellness Director educated staff immediately on 12/25/2022 and again at monthly meeting on 1/15/2023. There are two staff members schedule in SDCU on every shift.

Licensee's Proposed Overall Completion Date: 08/16/2023

Not Implemented ██████████ - 01/04/2024)

60a - Staff/Support Plan**4. Requirements**

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 5/8/23 there were 49 residents in the home, 20 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency and 5 residents who require the assistance of 2 staff persons to evacuate in an emergency. On this date there were only 3 direct care staff working in the home to assist residents to evacuate in the case of an emergency from 11:20pm until 6:30am on 5/9/23.

On 5/18/23 there were 49 residents in the home, 20 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency and 5 residents who require the assistance of 2 staff persons to evacuate in an emergency. On this date there were only 2 direct care staff working in the home to assist residents to evacuate in the case of an emergency from 11:10pm until 6:30am on 5/19/23.

Plan of Correction

Directed ██████████ 09/12/2023)

An additional staff member, making the total 4 team members, was scheduled on 3rd shift starting 5/31/2023 scheduled by ██████████ Resident Wellness Director. By 9/22/23 there will be a fire drill conducted during sleeping hours of our community to ensure four staff overnight is adequate for fire safety.

██████████ Executive Operations Officer also provided ██████████ with a copy of state regulations regarding staffing and the requirements on 5/31/2023 and again on 7/6/2023. ██████████ Resident Wellness Director will review of all schedules as well as an evaluation of census, resident assessments and support plans to ensure residents needs are met will be done with ██████████ Executive Operations Officer and ██████████ prior to posting them to ensure all shifts are staffed in accordance with regulation stated in the 2600 regulations discussed and put into place on 5/31/2023 as well as all non-covered call offs will be covered by a member of community's leadership team.

5/31/2023 Review of Residents and Mobility evacuation needs.

7/31/2023 Reviewed emergency fire plan with ██████████ of Fire & Life Safety Solutions who provided a 12-minute window that will safely allow us to get all residents that need evacuated to a fire safety compartment.

Fire Drills :

7/26/2023 2:25 pm 8:04 minutes 14 staff members

8/29/2023 2:30pm 7:14 minutes 11 staff members

60a - Staff/Support Plan (continued)

Directed:

By 9/19/23, the Executive Operations Officer will contact [REDACTED] Human Services Licensing Supervisor, and provide the dates and times for the next 3 unannounced fire drills.

9/12/23

Directed Completion Date: 09/08/2023

Not Implemented [REDACTED] - 01/04/2024)

88a - Surfaces

5. Requirements

2600.

88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 5/24/23, a 10" piece of wooden molding was not securely attached to the wall, directly beside the patio exit door in the SDCU.

On 5/24/23, the cover on the wall light in the main hallway of the SDCU was missing, exposing the light bulb.

Plan of Correction

Accept [REDACTED] - 09/12/2023)

Wooden modeling was repaired on 5/24/23 by [REDACTED] Safety and Maintenance Engineer. Inspecting molding and lights was added to the Manager on Duty Report on 7/29/2023 which is filled out every weekend to ensure building is in good repair.

On 5/31/2023 All members of leadership team were presented with copies of the MOD form by [REDACTED] Executive Operations Officer who pointed out the railing and light checks specifically on the form.

On 5/10/2023 the light cover was noted, and [REDACTED] Safety and Maintenance Engineer began looking for new fixture cover. It was ordered and is now in place. Placed by [REDACTED] Safety and Maintenance Engineer on 7/12/2023.

8/1/2023 Light coverings are monitored by [REDACTED] Safety and Maintenance Engineer noted daily on walk through of facility and weekly documented in the Tels System.

Licensee's Proposed Overall Completion Date: 08/16/2023

Implemented [REDACTED] - 01/04/2024)

89b - Hot Water Temperature

6. Requirements

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 5/24/23 at 11:11a.m., the hot water temperature at in the bathroom sink of bedroom #118 in the SDCU measured 130.4 degrees Fahrenheit, and on 5/25/23 at 4:32 p.m., it was 138.5 degrees Fahrenheit.

On 5/24/23 at 11:50 a.m., the hot water temperature at in the bathroom sink of bedroom #311 measured 128 degrees Fahrenheit and on 5/25/23 at 4:40 p.m., it was 140.5 degrees Fahrenheit.

89b - Hot Water Temperature (continued)

Plan of Correction

Accept () - 07/28/2023)

Hot water regulator and hot water tank were fixed by [REDACTED] on 5/25/2023. Temperature checks have been added to Tels system to ensure they are being check by [REDACTED] Safety and Maintenance Engineer. 6/4/2023 Weekly tests for hot water temps were added to the Tels System to ensure the water temp is being checked on a weekly basis.

Licensee's Proposed Overall Completion Date: 07/19/2023

Implemented () - 01/04/2024)

95 - Furniture and Equipment

7. Requirements

2600.

95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 5/24/23, the shut off valve was broken on a tank in the boiler room, causing an active water leak.

On 5/25/23, there was a broken water regulator on the water heater system in the boiler room.

On 5/25/23, the swivel chair in bedroom #118 was in disrepair. The metal base was removed and the chair was positioned directly on the floor.

Plan of Correction

Accept () - 09/12/2023)

Hot water tank was repaired on 5/25/2023 by [REDACTED]. [REDACTED] Safety and Maintenance Engineer will inspect boiler room daily starting on 5/31/2023 for any leaks as part of his morning routine prior to 9am morning meeting and report any leaking to [REDACTED] Executive Operations Officer.

5/24/2023 Chair had been dismantlement by a resident in the secured dementia unit. Chair was removed and a new chair put in its place that does not come apart on 5/24/2023, put in place by [REDACTED] Safety and Maintenance Engineer. Housekeeping will check rooms daily starting on 9/6/2023 and log any broken items in the resident rooms to be repaired.

Licensee's Proposed Overall Completion Date: 08/16/2023

Implemented () - 01/04/2024)

101j7 - Lighting/Operable Lamp

8. Requirements

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

On 5/24/23, resident #3 did not have access to an operable source of light that could be turned on/off at bedside.

Repeat Violation: 7/26/22 et al

101j7 - Lighting/Operable Lamp (continued)

Plan of Correction**Accept** [REDACTED] - 09/12/2023)

Resident #3 has a working light at bedside and was installed by [REDACTED] Safety and Maintenance Engineer. This was completed on bedside on 5/31/2023. This is checked by housekeeping on a daily basis when rooms are deep cleaned and is checked off on a log at that time. This has been in place since 3/24/2022 when building was acquired. All wellness and housekeeping staff will be re-educated to ensure all bedside lighting is working on a daily basis. On 7/31/2023 by [REDACTED] Resident Wellness Director and [REDACTED] Safety and Maintenance Engineer will be monitoring this course of action immediately

Licensee's Proposed Overall Completion Date: 08/16/2023

Not Implemented ([REDACTED] - 01/04/2024)

103f - Refrigerator/Freezer Temps

9. Requirements

2600.

103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

On 5/24/23 at 10:32 a.m., the temperature in the main kitchen's ice cream freezer was 12 degrees Fahrenheit and on 5/25/23 at 3:00 p.m. it was 8 degrees Fahrenheit.

Plan of Correction**Accept** [REDACTED] - 09/12/2023)

Freezer and Fridge temps are checked by [REDACTED] Dining Experience Director or a member of [REDACTED] staff and logged on clip board located on wall adjacent to the units daily before breakfast since 3/24/2023. The ice cream freezer components were cleaned on 5/30/2023 and freezer is at -3 degree when not being opened and closed as of 5/31/2023. Ice cream is now being stored in walk in freezer. 8/1/2023 [REDACTED] Executive Operations Officer has educated all kitchen staff to notify [REDACTED] immediately if any of the freezer temps are above zero-degree Fahrenheit. [REDACTED] will immediately notify [REDACTED] Safety and Maintenance engineer to get problem resolved.

Licensee's Proposed Overall Completion Date: 08/01/2023

Implemented [REDACTED] - 01/04/2024)

105g - Lint Removal and Duct Cleaning

10. Requirements

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 5/31/23, the dryers in the 2nd and 3rd floor laundry rooms were vented up into the attic of the home, creating a layer of lint varying from 1/8" to 3/4" thick, covering the floor, insulation, floor and wall joists and light fixture, posing a fire hazard.

Repeat Violation: 7/26/22 et al

105g - Lint Removal and Duct Cleaning (continued)

Plan of Correction

Accept [redacted] - 09/12/2023)

We discovered that the dryers were venting into the attic spaced upon yearly state inspection. The signed quote to vent the dryers and take care of the remaining lint are attached. [redacted] Safety and Maintenance Engineer is currently scheduling the project now that the quotes have been signed. Deposit check for work is being processed. Work will not start until Bauer Specialties receive deposit. [redacted] Safety and Maintenance Engineer was educated on 7/6/2023 by state auditor [redacted] regarding attic venting of dryers. Dryers are to be cleaned and inspected by [redacted] Safety and Maintenance Engineer monthly and was added to the Tels System on 5/31/2023 to ensure monthly inspections.

Bauer Specialty started the renovations to the attic on August 28th, 2023, and completed on 9/1/23. Spray foam was installed, and ventilation ducted was installed for dryer lint to be vented outside the building.

Licensee's Proposed Overall Completion Date: 09/06/2023

Implemented [redacted] - 01/04/2024)

132c - Fire Drill Records

11. Requirements

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 drill conducted on 8/1/22 does not indicate the exit route used.

The fire drill record for the drill conducted on 3/30/23 does not indicate a.m. or pm.

The fire drill record for the drill conducted on 4/28/23 does not indicate a.m. or p.m.

Repeat Violation: 7/26/22 et al

Plan of Correction

Accept [redacted] - 09/12/2023)

Safety and Maintenance Engineer [redacted] will submit fire drill log to [redacted] Executive Operations Officer after each fire drill to ensure it is filled out in its entirety to start on 5/31/2023

[redacted] was educated by [redacted] Executive Operation Officer and by state surveyor [redacted] to fill out fire drill log in full including am and pm to ensure all drills are practiced including sleeping hours on 5/24/2023.

[redacted] Fire Expert will conduct fire drill, inspection and training for staff on 7/31/2023. [redacted] inspection will give evacuation times required by community.

[redacted] Safety and Maintenance Engineer will review the fire safety log prior to bringing the log to [redacted] Executive Operations Officer within 24 hours of a drill to ensure log has been completely signed off and includes 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 is documented on the fire drill log

132c - Fire Drill Records (continued)

starting on 5/31/2023

Licensee's Proposed Overall Completion Date: 08/16/2023

Implemented [REDACTED] - 01/04/2024)

132e - Fire Drill Sleeping Hours

13. Requirements

2600.

132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The most recent fire drill conducted during sleeping hours was on 6/30/22 at 6:04 a.m.

Plan of Correction

Accept [REDACTED] - 07/28/2023)

[REDACTED] Safety and Maintenance Engineer was educated by [REDACTED] Executive Operations Officer on the need for fire drills during sleeping hours, and a new fire safety binder was giving to [REDACTED] by [REDACTED] that includes all the state specific regulations and state provided fire drill logs on 5/30/2023 Bi yearly sleeping hour fire drills were confirmed on Tels System on 5/31/2023 by [REDACTED] Executive Operations Officer

Sleeping hours fire drill was completed on 6/21/2023 by [REDACTED] Safety and Maintenance Engineer with [REDACTED] Resident Wellness Director at 11:45 pm

Licensee's Proposed Overall Completion Date: 07/19/2023

Implemented [REDACTED] 01/04/2024)

132g - Fire Drills Days/Times

14. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home regularly schedules 3 - 4 staff for the 11:00 p.m. - 7:00 a.m. shift. However, the home's fire drill records for the past year indicate the minimum amount of staff present for a fire drill was 5.

Plan of Correction

Directed [REDACTED] - 09/12/2023)

5/31/2023 Fire drill regulation provided to [REDACTED] Safety and Maintenance Engineer by [REDACTED] Executive Operations Officer 5/31/2023. Safety and Maintenance Engineer was included in the total for staff members while conducting a fire safety evacuation drill but did not participate. In the future, all documentation will only include those who participated. By 9/22/23 there will be a fire drill conducted during sleeping hours of our community to ensure four staff overnight is adequate for fire safety.

132g - Fire Drills Days/Times (continued)

Monthly drills as well as bi-yearly sleeping hour drills were clarified in the Tels System on 5/31/2023. [REDACTED] Executive Operations Officer provided [REDACTED] with a copy of state regulations regarding staffing and the requirements on 5/31/2023 and again on 7/6/2023. [REDACTED] Resident Wellness Director will review all schedules with [REDACTED] Executive Operations Officer prior to posting them to ensure all shifts are staffed in accordance with regulation stated in the 2600 regulations discussed and put into place on 5/31/2023 as well as all non-covered call offs will be covered by a member of community's leadership team.

There are four staff scheduled on 3rd shift starting 5/31/2023 scheduled by [REDACTED] Resident Wellness Associate.

5/31/2023 Review of Residents and Mobility evacuation needs.

7/31/2023 Reviewed emergency fire plan with [REDACTED] of Fire & Life Safety Solutions who provided a 12-minute window that will safely allow us to get all residents that need evacuated to a fire safety compartment.

Fire Drills:

7/26/2023 2:25 pm 8:04 completed with 14 staff.

8/29/2023 2:30pm 7:14 completed with 11 staff.

Directed:

By 9/19/23, the Executive Operations Officer will contact [REDACTED], Human Services Licensing Supervisor, and provide the dates and times for the next 3 unannounced fire drills.

[REDACTED] 9/12/23

Directed Completion Date: 09/08/2023

Implemented [REDACTED] - 01/04/2024)

132h - Designated Meeting Place

15. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

Multiple staff interviews indicate the home does not evacuate all residents to a designated meeting place away from the building or within the fire-safe area during fire drills. Staff indicate residents requiring use of a Hoyer lift to transfer from bed to wheelchair are not being evacuated during fire drills if they are not already in their wheelchair. Staff also indicate residents in the SDCU are not being properly evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Accept [REDACTED] - 09/12/2023)

Fire drills have been conducted to ensure staff are able to evacuate all residents to a designated meeting place away from the building Fire Safety will be gone over by [REDACTED] Safety and Maintenance Engineer on 7/31/2023. [REDACTED] has a call out to Erie Fire Chief to set up some formal training with them date tbd. The education on 7/31/2023 Will include evacuation of SDCU to the courtyard out of the gate to the front parking lot. The doors going into SDCU are fire safe doors.

132h - Designated Meeting Place (continued)

██████████ from Fire & Life Safety Solutions will educate staff on 7/31/2023 regarding designated meeting places depending on where they are located in the building. This information will be gone over again with all staff at Quarterly Staff Meeting on 8/15/2023. All fire drill monitoring is done through the Tels System by ██████████ Safety and Maintenance Engineer effective 5/31/2023

We do not evacuate the entire building. Residents are moved to the designated fire safe compartment that is appropriate depending on where the fire drill is done for. 5/31/2023 fire drill done to demonstrate the fire safe compartments on each floor. If entire building would need evacuated the Employee Parking Lot is the designated space staff was educated on this 7/31/2023 by ██████████ Resident Wellness Director and ██████████ Safety and Maintenance Engineer.

7/26/2023 at 2:25 pm all residents were safely evacuated to the fire safety compartments in 8:04 minutes.

Licensee's Proposed Overall Completion Date: 08/16/2023

Implemented ██████████ - 01/04/2024)

162c - Menus Posted

16. Requirements

2600.

162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 5/24/23, the menu for the week of 5/21/23 was posted. However, the menu for the week of 5/28/23 was not posted.

Repeat Violation: 7/26/22 et al

Plan of Correction

Accept ██████████ - 07/14/2023)

██████████ Dining Experience Director was educated by ██████████ Executive Operations Officer on 5/25/2023 that at least 2 weeks worth of menus are to be posted in a conspicuous area at all times. Items removed from window board to make room for two running menus on 5/25/2023. Executive Operations Officer will check board Monday thru Friday on way to morning meeting starting 5/25/2023

Licensee's Proposed Overall Completion Date: 07/06/2023

Implemented ██████████ - 01/04/2024)

185a - Implement Storage Procedures

17. Requirements

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

The home's policy for narcotics and controlled substances indicates, "The narcotic count will be between 2 authorized, trained team members and reconciled at the beginning of each shift. If the count cannot be reconciled, efforts to investigate and reconcile will be thorough and include calling the Director of Resident Care Services, Executive

185a - Implement Storage Procedures (continued)

Director and Regional Director of Resident Care & Staff Development and/or the Senior Vice President of Operations prior to leaving shift."

Resident #4 is prescribed Temazepam 7.5mg - Take 1 capsule by mouth at bedtime. On 5/24/23 at 3:45 p.m. there were 19 Temazepam capsules belonging to resident #4 present in the home; however, resident #4's Medication Monitoring/Control Record indicates there were 20 capsules present.

Plan of Correction

Accept [redacted] - 09/12/2023)

[redacted] Residents Wellness Director will meet with Medication Passers and all nurses to review policy on counting on and off between shifts with narcotics signed training sheet will be available on 7/31/2023

[redacted] Resident Wellness Director will have medication carts audited weekly and document the completion of findings as of 5/31/2023

[redacted] Resident Wellness Director conducted an investigation in an attempt to reconcile or determine the root cause of discrepancy on 5/31/23. [redacted] did this by speaking with every member of staff that had signed on the med cart during the time the pill was missed. Root cause was team members not visualizing each card in its entirety. Education given on this 5/31/2023 by [redacted]

Licensee's Proposed Overall Completion Date: 08/01/2023

Implemented [redacted] - 01/04/2024)

237a - Activities

18. Requirements

2600.

237.a. The following types of activities shall be offered at least weekly:

Description of Violation

On 5/24/23, 5/25/23 and 5/31/23 no activities were observed occurring for residents in the SDCU. Multiple staff interviews indicate the home has not offered various types of activities to all residents in the SDCU for several weeks.

Plan of Correction

Accept [redacted] - 07/28/2023)

Activities have been occurring in SDCU however at a minimal amount. [redacted] is our new Life Story/Life Stages Director. [redacted] is actively working on a plan to beef up activities in the SDCU. [redacted] will have new calendar done that will reflect that by 7/31/2023 Onn7/31/2023 [redacted] will speak to all of Wellness Staff regarding engagement with residents in SDCU. Our staff does a more sitting than they should and then claim they are short staffed.

Effective 5/31/2023 [redacted] Life Story/Stages Director will have [redacted] approve activities calendar before the beginning of each month to ensure engagement and enrichment in SDCU.

Licensee's Proposed Overall Completion Date: 07/19/2023

Implemented [redacted] - 01/04/2024)