pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **INTEGRACARE ERIE LLC**
LEGAL ENTITY

To operate **THE RESIDENCE AT PRESQUE ISLE BAY**
NAME OF FACILITY OR AGENCY

Located at **1012 WEST BAYFRONT PARKWAY, ERIE, PA 16507**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **138**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 22**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **June 11,** **2024** until **December 11,** **2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453501**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: JUNE 11, 2024

[redacted]
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, Office of Long-Term Living licensing inspections on November 16, 2023, November 21, 2023, February 13, 2024, February 14, 2024, February 15, 2024 and February 21, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (45350) dated March 24, 2024, to March 24, 2025 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) ;(5) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from June 11, 2024 to December 11, 2024.

All violations specified on the LISs must be corrected by the dates specified on the reports 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.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	X	Fine Per resident Per day	=	Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
16(c)	III	48		$3		$144	15 calendar days from mailing date of this letter
42(b)	II	48		$5		$240	5 calendar days from mailing date of this letter
92	III	48		$3		$144	15 calendar days from mailing date of this letter
101(j)	III	48		$3		$144	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until each violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with each regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

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: *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]

Legal Entity

Name: *INTEGRACARE ERIE LLC*

Address: [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**: *73* **Waking Staff**: *55*

Inspection Information

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

Reason: *Incident, Monitoring* **Exit Conference Date**: *11/21/2023*

Inspection Dates and Department Representative

11/16/2023 - On-Site: [redacted]
11/21/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *54*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *1ST FLOOR* **Capacity**: *22* **Residents Served**: *13*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *53*

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

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

Inspections / Reviews

11/16/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/17/2023*

01/02/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/26/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *01/05/2024*

01/11/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/26/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/22/2024*

05/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/26/2024*

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

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 10/16/23, the [redacted] of resident #1 and resident #2 reported to staff person A that the residents' pre-paid debit card was stolen from their apartment and was used by an unauthorized person at Walmart. Staff person A reported this incident to staff person B on 10/16/23. However, this incident was not reported to the local Area Agency on Aging until 10/25/23.

Sometime between 10/5/23 – 10/11/23 in the secured dementia care unit (SDCU), staff person C entered resident #3's bedroom and found [redacted]r laying on [redacted] bed dressed only in a shirt, with resident #4, who was naked from the waist down, leaning over resident #3. Staff person C reported the incident to staff person D, who reported the incident to staff person E. However, this incident was not reported to the local Area Agency on Aging.

Plan of Correction ***Accept [redacted] - 01/11/2024)***

Starting on 12/21/23 all reports to AOA (Area Office of Aging) will be submitted by the administrator or designee immediately, for all report allegations of abuse to AOA. The date, time, and phone number of the AOA representative will be documented in the reportable sent to DHS after all parties are safe, but within the first 24 hours. This plan was developed by Executive Operations Officer (EOO) [redacted] and discussed and put in place by [redacted] Resident Wellness Director (RWD) on 12/21/23. Beginning on 12/21/23 all incidents will be discussed at morning meeting by [redacted], RWD or [redacted], EOO. A binder will be monitored by [redacted], RWD weekly to ensure that all updated reportables are filed. A training through Senior Living University on the correct method of reporting will be conducted on 1/23/23 at the quarterly all staff meeting.

A step implementing procedures to ensure any suspected abuse of a resident is immediately reported 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) to include:
Upon receiving a report of abuse, the home will:
1. 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.
2. If the report involves a staff person, the home will immediately suspend the staff person involved in the alleged abuse or place the staff person on a plan of supervision that is developed in conjunction with the Department.
3. Report the abuse allegation to the Department in accordance with § 2600.16, including the plan to supervise or suspend the alleged perpetrator.
4. Immediately report the allegation of abuse to the resident and the resident's designated person.
5. Begin an internal investigation of the abuse as required by the procedures indicated in § 2600.41.
will be conducted at the all-staff meeting on 1/23/24 by [redacted], EOO.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented [redacted] - 05/17/2024)

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

On 10/16/23, the [redacted] of resident #1 and resident #2 reported to staff person A that the residents' pre-paid debit card was stolen from their apartment and was used by an unauthorized person at Walmart. Staff person A reported this incident to staff person B on 10/16/23. However, this incident was not reported to the Department until 10/25/23.

Sometime between 10/5/23 – 10/11/23 in the SDCU, staff person C entered resident #3's bedroom and found [redacted] laying on [redacted] bed dressed only in a shirt, with resident #4, who was naked from the waist down, leaning over resident #3. Staff person C reported the incident to staff person D, who reported the incident to staff person E. However, this incident was not reported to the Department.

Plan of Correction ***Accept [redacted] - 01/11/2024)***

Starting on 12/21/23 all reports to AOA (Area Office of Aging) will be submitted by the administrator or designee immediately, for all report allegations of abuse to AOA. The date, time, and phone number of the AOA representative will be documented in the reportable sent to DHS after all parties are safe, but within the first 24 hours. An internal follow up with three residents in the community each week for 3 months will occur to ensure that there are no other items stolen. This plan was developed by Executive Operations Officer (EOO) [redacted] and was discussed and put in place by [redacted], Resident Wellness Director (RWD) on 12/21/23. Beginning on 12/21/23 all incidents will be discussed at morning meeting by [redacted]. A binder will be monitored by [redacted], RWD weekly to ensure that all updated reportables are filed. A training by Senior Living University on the correct method of reporting will be conducted on 1/23/24 at the quarterly all staff meeting.

A step implementing procedures to ensure any suspected abuse of a resident is immediately reported 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) to include:
Upon receiving a report of abuse, the home will:
1. 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.
2. If the report involves a staff person, the home will immediately suspend the staff person involved in the alleged abuse or place the staff person on a plan of supervision that is developed in conjunction with the Department.
3. Report the abuse allegation to the Department in accordance with § 2600.16, including the plan to supervise or suspend the alleged perpetrator.
4. Immediately report the allegation of abuse to the resident and the resident's designated person.
5. Begin an internal investigation of the abuse as required by the procedures indicated in § 2600.41.
will be conducted at the all-staff meeting on 1/23/24 by [redacted], EOO.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Not Implemented [redacted] - 05/17/2024)

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.

42b - Abuse *(continued)*

Description of Violation

On 10/16/23, the [redacted] of resident #1 and resident #2 reported to staff person A that the residents' pre-paid debit card was stolen from their apartment and was used by an unauthorized person at Walmart. On 11/14/23, staff person F admitted to staff person B that [redacted] used the pre-paid debit card. Erie City Police Department charged staff person F with Access Device Issued to Another Who Did Not Authorize Use, Theft By Unlawful Taking – Movable Property, and Receiving Stolen Property.

Repeat Violation: 9/27/2022 et al

Plan of Correction ***Accept [redacted] - 01/11/2024)***

The immediate step upon information of staff person F committing said action was a suspension pending investigation. After staff person F admitted to staff person B that the pre-paid debit card was used by staff person F there was a voluntary termination. Staff person F is no longer an employee as of [redacted]/23, is non-rehirable, and is not permitted back into the community. Starting on 12/21/23 all reports to AOA (Area Office of Aging) will be submitted by the administrator or designee immediately, for all report allegations of abuse to AOA. The date, time, and phone number of the AOA representative will be documented in the reportable sent to DHS after all parties are safe, but within the first 24 hours. An internal follow up with three random residents in the community each week for 3 months will occur to ensure that there are no other items stollen will start the week of 11/20/23.

A reeducation step including [redacted], Supervisor for Protective Services through Erie's local Area Agency on Aging (GECAC) will be a reeducation for all staff on resident rights, specifically financial. This is tentatively scheduled for 2/27/24.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Not Implemented [redacted] - 05/17/2024)

4. 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 #3 resides in the SDCU. [redacted] assessment and support plan (RASP), dated [redacted] 23, indicates [redacted] is diagnosed Dementia - Unspecified, needs moderate supervision in the home, tends to wander, and has a moderate problem with awareness cognition, having knowledge of only past and immediate present.

Resident #4 resides in the SDCU. [redacted] RASP, dated [redacted] 23, indicates [redacted] is diagnosed with Psychological Dementia w/o Behavioral Disturbance, needs moderate supervision in the home, tends to wander, and has a moderate problem with awareness cognition, having knowledge of only past and immediate present.

On 10/4/23 at approximately 9:15am, staff person G found resident #3 in resident #4's bedroom. Both residents were naked in bed and resident #4's [redacted] was observed on resident #3's leg.

Sometime between 10/5/23 – 10/11/23, staff person C entered resident #3's apartment and found [redacted] laying on [redacted] bed dressed only in a shirt, with resident #4, who was naked from the waist down, leaning over resident #3.

42b - Abuse (continued)

The home failed to provide adequate supervision , nor did they have the residents assessed to determine their ability to consent.

Repeat Violation: 9/27/2022 et al

Plan of Correction ***Directed [redacted] - 01/11/2024)***

[redacted] *Resident Wellness Director will review all scheduled prior to posting them to ensure all shifts are staffed in accordance with the regulations stated in the 2600.42b regulations. This has been discussed and put in place on 12/21/23 as well as all non-covered call offs will be covered by a member of the community's leadership team.*

The immediate step performed by staff person G was to redirect each resident back to their respective rooms. There were 15-minute check put in place with no further sexual contact noted and neither resident was showing signs or symptoms of trauma. There have been no room changes at this time and there have been no other sexual contact noted involving resident #3 and #4 since the non-reported incident between 10/5/23-10/11/23. There will be a training conducted at the all-staff quarterly meeting on 1/23/24.

A reeducation step including [redacted] for Protective Services for Erie's local Area Agency on Aging (GECAC) will be a reeducation for all staff on identifying and preventing sexual abuse. This is tentatively scheduled for 2/27/24.

A monitoring step will include a weekly check by [redacted], EOO or designee. This will review the current census, and resident RASPs for care needs, to include but not limited to supervision needs, behavioral and cognitive needs, mobility needs, and two person assists. RASPs will be updated within 24 hours of any change in needs. Staffing levels will be reviewed to evaluate and ensure that sufficient staff are scheduled to meet the needs of the residents as indicated in their RASPs and will be adjusted accordingly based on the ongoing weekly reviews conducted by [redacted] or designee. Documentation of reviews will be kept and reviewed at morning standup.

Proposed Overall Completion Date: 01/04/2024

Directed:
By 1/15/24 and weekly thereafter, weekly checks indicated above will be conducted.
[redacted] ***1/11/24***

Directed Completion Date: *01/15/2024*

Not Implemented [redacted] - 05/17/2024)

60a - Staff/Support Plan

5. 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 5/31/23 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 event of an emergency from 11:00 p.m. until 6:30 a.m. on 6/1/23.

60a - Staff/Support Plan (continued)

On 6/12/23 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 event of an emergency from 11:00 p.m. until 6:30 a.m. on 6/13/23.

On 6/16/23 there were 52 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 event of an emergency from 11:00 p.m. until 6:30 a.m. on 6/17/23.

On 9/6/23 there were 48 residents in the home, 18 with mobility needs requiring assistance of 1 staff person to evacuate in an emergency and 4 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 event of an emergency from 11:00 p.m. until 4:00 a.m. on 9/7/23.

Repeat Violation: 6/15/2023

Plan of Correction ***Directed [redacted] - 01/11/2024)***

An additional staff member, making the total team members 4, was scheduled on 3rd shift starting 9/7/23 scheduled by [redacted], Resident Wellness Director. [redacted], Executive operations Officer reviewed the mobility, acuity, and staffing regulations with [redacted], Resident Wellness Director and will review each schedule before posting to ensure that all staffing requirements are met.

A monitoring step will include a weekly check by [redacted], EOO or designee. This will review the current census, and resident RASPs for care needs, to include but not limited to supervision needs, behavioral and cognitive needs, mobility needs, and two person assists. RASPs will be updated within 24 hours of any change in needs. Staffing levels will be reviewed to evaluate and ensure that sufficient staff are scheduled to meet the needs of the residents as indicated in their RASPs and will be adjusted accordingly based on the ongoing weekly reviews conducted by [redacted], EOO or designee. Documentation of reviews will be kept and reviewed at morning standup.

Proposed Overall Completion Date: 01/04/2024

Directed:
By 1/15/24 and weekly thereafter, weekly checks indicated above will be conducted.
S[redacted] 1/11/24

Directed Completion Date: *01/15/2024*

Implemented[redacted] 05/17/2024)

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 11/16/23 at 2:15 p.m., the hot water temperature in the 1st floor, right side common bathroom sink measured 126.1 degrees Fahrenheit and on 11/16/23 at 4:30 p.m., it was 118.2 degrees Fahrenheit.

On 11/16/23 at 2:18 p.m., the hot water temperature in the 1st floor, left side common bathroom sink measured 127.9 degrees Fahrenheit and on 11/16/23 at 4:33 p.m., it was 118.5 degrees Fahrenheit.

Plan of Correction ***Accept [redacted] - 01/11/2024)***

The immediate action taken by [redacted] Safety and Maintenance Engineer was to turn down the overall water temperature for the community. An electronic tracking system, TELs, will prompt a weekly check for Safety and Maintenance Engineer, [redacted] to check and record the water temperature throughout the community starting on 11/16/23.

Daily checks of hot water temperatures will be completed, documentation will be kept. Any hot water temperature exceeding 120 degrees Fahrenheit shall immediately be reported to [redacted], EOO and immediate action shall be taken to reduce the temperature to 120 degrees Fahrenheit or lower. This will begin on 1/4/23 and will be completed by [redacted], Safety and Maintenance Engineer.

A reeducation step on safe water temperatures and the risk of unsafe water temperatures to residents will be conducted my [redacted], Safety and Maintenance Engineer on 1/23/24 at an all-staff meeting. Any hot water temperatures exceeding 120 degrees Fahrenheit shall immediately be reported to the EOO. Documentation of education shall be kept.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented [redacted] - 05/17/2024)

92 - Windows

7. 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 11/16/23, there was an approximate 5" x 4" hole in the screen of the window to the right of the door to the SDCU courtyard.

Repeat Violation: 2/14/2023, 7/26/2022 et al

Plan of Correction ***Directed [redacted] - 01/11/2024)***

Window screen in SDCU to the right of the door to the courtyard was replaced on 12/21/23 by Executive

92 - Windows (continued)

Operations Officer [redacted]. There will be a monthly check added to Tels, electronic maintenance tracking system, on 12/21/23 for all Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

[redacted], EOO will reeducate all staff at the all-staff meeting on 1/23/24 regarding the requirement that all windows, including windows in doors, must be in good repair and securely screened. Any damaged windows or screens, or missing screens, shall be reported to the EOO and SME immediately. Documentation of training shall be kept.

Proposed Overall Completion Date: 01/04/2024

Directed:
By 1/15/24 and weekly thereafter, the COO or designated staff person shall inspect all areas of the home to ensure all windows, including doors with windows, are in good repair, and all operable windows have screens that are securely attached and in good repair. Any deficiencies discovered shall immediately be repaired or replaced. Documentation of inspections shall be kept. Please indicate begin date.
[redacted]1/11/24

Directed Completion Date: *01/15/2024*

Not Implemented[redacted] - 05/17/2024)

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 11/16/23 at 10:36 a.m. resident #5 did not have access to a source of light that could be turned on/off at bedside.

Repeat Violation: 2/14/2023, 7/26/2022 et al

Plan of Correction ***Accept[redacted] - 01/11/2024)***

The immediate action was to place a new operable light source next to resident #5s bedside. This was completed on 11/22/23. Starting 12/21/23 all lamps or other source of lighting that can be turned on at beside are included in the room turnover checklist for housekeeping/maintenance.

Daily, the Hospitality Associates or designee shall inspect all resident bedrooms to ensure each resident has an operable lamp or other source of lighting that can be turned on/off at bedside. Any damaged or missing light sources discovered shall immediately be repaired or replaced. Documentation of inspections shall be kept.

[redacted], EOO will reeducate all staff persons at the all-staff meeting on 1/23/24 on the requirement that each resident shall have an operable lamp or source of light that can be turned on/off at bedside. Any damaged or missing light sources shall immediately be repaired or replaced. Documentation of education shall be kept.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Not Implemented[redacted] - 05/17/2024)

101r - Bedroom - shades/drapes/window covering

9. Requirements

2600.
101.r. There must be drapes, shades, curtains, blinds or shutters on the bedroom windows. Window coverings must be clean, in good repair, provide privacy and cover the entire window when drawn.

Description of Violation

On 11/16/23, there were approximately 10 broken slats in the blind covering the right side window in bedroom #101.

Plan of Correction ***Accept [redacted]/11/2024)***

The immediate action was to remove the broken blinds from resident bedroom #101 and have them replaced. This was completed on 11/22/23 by [redacted], Safety and Maintenance Engineer. Starting 12/21/23 a daily check of all drapes, shades, curtains, blinds or shutters on the bedroom windows, window coverings which must be clean, in good repair, provide privacy and cover the entire window when drawn are included in the room turnover checklist for housekeeping/maintenance.

Licensee's Proposed Overall Completion Date: *01/04/2024*

Implemented [redacted] - 05/17/2024)

132d - Evacuation

10. 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 most recent maximum safe evacuation time determined by a fire safety expert on 7/31/23 was 12 minutes. The previous maximum safe evacuation time determined by a fire safety expert on 3/14/22 was 12 minutes. From 3/15/23 - 7/30/23, the home did not have a maximum safe evacuation time specified in writing within the past year by a fire safety expert. The home exceeded an evacuation time of 2 minutes 30 seconds during the following drills:

Date of Drill:	***Time of Drill:***	***Evacuation Time:***
4/28/23	*11:19 p.m.*	*14 minutes*
5/31/23	*4:05 a.m.*	*17 minutes*
6/21/23	*11:45 p.m.*	*18 minutes*

Plan of Correction ***Directed [redacted] - 01/11/2024)***

[redacted] *Wellness Director will review all scheduled prior to posting them to ensure all shifts are staffed in accordance with the correct staffing hours per resident as well as acuity and emergency protocols. This has been discussed and put in place by [redacted], Executive Operations Officer and [redacted], Resident Wellness Director on 8/11/23 as well as all non-covered call offs will be covered by a member of the community's leadership team.*

A monitoring step includes [redacted], EOO or designee to review the fire drill log immediately after each fire drill, to ensure all residents are evacuated 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. Documentation will be kept.

132d - Evacuation (continued)

All fire drills conducted after 8/11/23 have been performed by The Residence at Presque Isle Bay under the maximum safe evacuation time determined by a fire safety expert on 7/31/23. The times are below:

Date of the Drill:	*Time of the drill:*	*Evacuation Time:*
8/29/23	*2:30pm*	*7.14 Minutes*
9/14/23	*11:15pm*	*10.05 Minutes*
10/30/23	*10:58am*	*6.43 Minutes*
11/30/23	*4:35pm*	*6.15 Minutes*

Proposed Overall Completion Date: 01/04/2024

Directed:
By 1/15/24 and prior to posting each future schedule, schedule reviews shall be conducted as indicated above.
[redacted] ***1/11/24***

Directed:
By 1/15/24 and monthly thereafter, fire drill log reviews shall be conducted as indicated above.
[redacted] ***1/11/24***

Directed Completion Date: *01/15/2024*

Implemented ([redacted]/17/2024)

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**: *03/24/2025*

Address: *1012 WEST BAYFRONT PARKWAY, ERIE, PA 16507*

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

Administrator

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

Legal Entity

Name: *INTEGRACARE ERIE LLC*

Address: [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**: *65* **Waking Staff**: *49*

Inspection Information

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

Reason: *Renewal, Complaint, Incident, Interim* **Exit Conference Date**: *04/01/2024*

Inspection Dates and Department Representative

02/13/2024 - On-Site: [redacted]
02/14/2024 - On-Site:
02/15/2024 - On-Site:
02/21/2024 - On-Site:
03/13/2024 - Off-Site:
03/14/2024 - Off-Site:

Resident Demographics

General Information

License Capacity: *138* **Residents Served**: *48*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Lifestories* **Capacity**: *22* **Residents Served**: *12*

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

02/13/2024 - Full

Lead [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/25/2024*

05/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/16/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *05/06/2024*

05/13/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *05/16/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *05/16/2024*

05/17/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *05/16/2024*

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 12/7/23 at 1:50 p.m., resident #1 was found in [redacted] bedroom lying on [redacted] side in between a recliner and a dresser. The resident hit [redacted] head, sustained a skin tear to the top of [redacted] right wrist and a small hematoma on the left/ back side of [redacted] head. The resident was sent to the hospital for evaluation and was diagnosed with a right wrist fracture. However, this incident was not reported to the Department until 2/15/24.

Repeat Violation: 5/24/2023

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The immediate and corrective action upon the notification that the incident was not reported to DHS was Executive Operations Officer,[redacted] reported the incident to DHS on 2/14/24.

The monitoring action taken by[redacted], Resident Wellness Director will be a weekly review for all reportable incidents and conditions will be conducted to ensure all reportable incidents and conditions are reported to the Department in accordance with regulation 2600.16c. Documentation of reviews will be kept starting May 6th 2024.

The preventative action taken by [redacted], EOO and [redacted], RWD is a training for reportable incidents to ensure they are submitted in a timely manner in accordance with 2600. 16c will be conducted by [redacted] EOO planned for the quarterly all staff meeting on 4/24/24.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented ([redacted] 05/17/2024)

20b1 - Financial Records

2. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
1. The home shall keep a record of financial transactions with the resident, including the dates, amounts of deposits, amounts of withdrawals and the current balance.

Description of Violation

The home manages finances for resident #2. Resident #2's Resident Personal Cash Tracking Record indicates a balance of $119.00; however, on 2/14/24, the actual amount of cash on hand was $119.10.

The home manages finances for resident #3. Resident #3's Resident Personal Cash Tracking Record indicates a balance of $87.00; however, on 2/14/24, the actual amount of cash on hand was $87.28.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The immediate and corrective action taken by [redacted], Administrative Services Director was to change and record the correct amount shown for both resident #2 and #3's actual amount of cash on hand on 2/15/24.

The preventative action taken by [redacted], Administrative Serivces Director is to audit the Personal Cash

20b1 - Financial Records (continued)

Tracking Records once a month and to no longer accept coins in the personal resident funds starting on 4/23/24.

Licensee's Proposed Overall Completion Date: *04/23/2024*

Not Implemented [redacted] - 05/17/2024)

20b3 - Written Receipts

3. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
3. The home shall obtain a written receipt from the resident for cash disbursements at the time of disbursement.

Description of Violation

On 12/13/23, a cash disbursement of $13.00 was made to resident #3. However, the home did not obtain the resident's signature for the receipt of the disbursement.

Plan of Correction ***Directed ([redacted] - 05/13/2024)***

The initial and ongoing action will be a monthly auditing step, to include an audit of all resident Personal Cash Tracking Records, to ensure signatures are present for all distributions with documentation kept [redacted], Administrative Serivces Director starting May 6th 2024.

The preventative action taken by [redacted], Administrative Serivces Director, starting on 4/23/24 is to obtain the signature of the resident withdrawing money out of their resident fund the day they withdraw the funds.

Proposed Overall Completion Date: 05/06/2024

Directed:
By 5/15/24, the administrator or designee will obtain resident #3's signature for the 12/13/23 cash disbursement of $13.00.
[redacted]13/24

Proposed Overall Completion Date: 05/15/2024

Directed Completion Date: *05/15/2024*

Not Implemented ([redacted] 05/17/2024)

20b8 - Quarterly Account

4. Requirements

2600.
20.b. If the home provides assistance with financial management or holds resident funds, the following requirements apply:
8. The home shall give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf on a quarterly basis.

Description of Violation

Resident #2 has not received a quarterly account of financial transactions prior to 2/13/24.
Repeat Violation: 12/20/2022

20b8 - Quarterly Account (continued)

Resident #3 has not received a quarterly account of financial transactions prior to 2/13/24.

Resident #4 has not received a quarterly account of financial transactions prior to 2/13/24.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The immediate and corrective action taken by [redacted] was to give the resident and the resident's designated person, an itemized account of financial transactions made on the resident's behalf for resident #2, #3, and #4.

The preventative action taken by [redacted] is that all residents with a resident fund will receive an itemized account of financial transactions made on the resident's behalf for resident to both the resident and the resident's designated party, if necessary, starting with the quarter following 4/23/24.

Licensee's Proposed Overall Completion Date: *06/01/2024*

Not Implemented [redacted] - 06/03/2024)

25a - Written Contract and Review

5. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #5, admitted [redacted]/21, has a resident-home contract with the previous owner; however, the home changed ownership in March 2022 and resident #5 does not have a resident-home contact with the new owner.

Repeat Violation: 12/20/2022

Plan of Correction ***Accept[redacted] 05/10/2024)***

The immediate and corrective action by [redacted] Community Relations Director, was to send out an updated, current company contract to both the resident #5 and resident #5's designated person on 4/25/24. [redacted], EOO will also conduct an ongoing monthly audit, to include an audit of all resident files to ensure a resident-home contract is present. Documentation will be kept starting May 6th, 2024.

The preventative action taken by [redacted], Community Relations Director is a signed contract by every new admission on the day of the resident's admission starting 4/23/24.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Implemented [redacted] - 05/17/2024)

26a - Quality Management Plan

6. Requirements

2600.
26.a. The home shall establish and implement a quality management plan.

26a - Quality Management Plan *(continued)*

Description of Violation

The home's quality management plan is called "Continuous Quality Improvement (CQI)". The Community Operating Standards Manual indicates the CQI Action Plan Process will comply with 2600.26(a), and indicates, "The Action Plan will be reviewed monthly by the Executive Director and appropriate members of the management team and documented detailing the date and time of the review, members present, findings and subsequent follow-up actions required." However, the home did not complete an Action Plan Review during the months of November 2023, December 2023, and January 2024.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The immediate and corrective action taken by [redacted] EOO was the conduction of a S.Q.I.R.T meeting to encompass the Continuous Quality Improvement (CQI)that complies with regulation 2600. 26.a. starting on February 29th 2024.

The preventative action taken by [redacted] is the creation of a S.Q.I.R.T committee and a monthly meeting to discuss the community's quality management plan starting on 2/29/24.

Licensee's Proposed Overall Completion Date: *04/23/2024*

Implemented [redacted] 05/17/2024)

42b - Abuse

7. 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 was admitted on [redacted]3 and had the following witnessed and unwitnessed falls in the home:
On 11/21/23 at 12:48 a.m., resident #1 had an unwitnessed fall and was sent to the hospital for evaluation due to neck pain and a heart rate of 42 beats per minute.
On 12/7/23 at 1:50 p.m., resident #1 was found in [redacted] bedroom lying on [redacted]left side in between a recliner and a dresser. The resident hit [redacted] head, sustained a skin tear to the top of [redacted] right wrist and a small hematoma on the left/ back side of [redacted]head. The resident was sent to the hospital for evaluation and was diagnosed with a right wrist fracture.
On 12/9/23 at 5:30 p.m., resident #1 had an unwitnessed fall in [redacted] bedroom, hit [redacted] head, complained of severe head pain, and was sent to the hospital for evaluation.
On 12/10/23 at 3:34 a.m., resident #1 had an unwitnessed fall when trying to use the bathroom by [redacted] and slipped, resulting in an open wound on [redacted] nose and a large lump on [redacted] forehead. The resident was sent to the hospital for evaluation and was admitted with the diagnosis of a cervical neck fracture.
On 12/31/23 at 7:58 p.m., resident #1 was walking around [redacted] room unassisted and fell by [redacted]bedside.
On 1/3/24 at 9:26 a.m., resident #1 was found lying on the floor in the hallway, complained of right knee/groin pain, was sent to the hospital for evaluation and was diagnosed with a right femur fracture, requiring admission to a skilled nursing facility.

The home was aware of resident #1's tendency to fall and failed to provide supervision in the home.

42b - Abuse (continued)

Repeat Violation: 5/24/2023 et al

Plan of Correction ***Directed (/13/2024)***

No immediate or corrective action was taken due to the resident no longer residing within the community at the date of the violation.

All residents were reassessed for their need for supervision, need for assistance with transfers/mobility, and fall risk. Any changes will be communicated to the resident, their designee and physician within 24 hours and documented on the resident RASP within 5 days. A 30-day notice of these assessments was communicated to all responsible parties by , Executive Operations Officer on 3/27/24. All reassessments were completed by 5/1/24. Along with this a weekly review starting 5/13/24 for incidents for changes in resident needs, medical conditions, mobility, and medications as it may contribute to falls. Any changes will be communicated to the resident, their designee and physician within 24 hours and documented on the resident RASP within 5 days. This is all completed by , Resident Wellness Director.

The preventative action taken by , Executive Operations Officer and , Resident Wellness Director was that a reassessment must be completed on a resident that has a cause resulting in a significant change starting 4/23/24. Along with this, , Executive Operations Officer and , Resident Wellness Director starting 4/23/24 will implement company policy regarding exclusionary attributes that deem a returning or current resident unsafe within the scope of the care the community can provide at that time. Upon this determination, a 30-day notice will be submitted to the resident and their designated person from the residence.

Proposed Overall Completion Date: 05/13/2024

Directed:
All resident discharges must be in accordance with 2600.228.
5/13/24

Directed Completion Date: *05/13/2024*

Not Implemented - 05/17/2024)

42c - Treatment of Residents

8. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Staff interviews indicate resident #6 and resident #7 do not get along and are argumentative. On 2/13/24 at approximately 7:00 p.m. in the secured dementia care unit (SDCU), resident #6 grabbed resident #7's purse, resulting in resident #7 hitting resident #6 in the back with a closed fist, resulting in no injury.

42c - Treatment of Residents *(continued)*

Plan of Correction ***Accept - 05/10/2024)***

The immediate action taken by [redacted], Resident Wellness Director was fifteen-minute checks placed on both resident #6 and resident #7 for 24 hours to ensure the safety of both residents.

The corrective action completed by [redacted], Resident Wellness Director was updating both Resident #6 and #7's RASP to ensure that by residents are treated with dignity and respect by 4/10/24.

The preventative action taken by [redacted], Resident Wellness Director is to ensure that all residents shall be treated with dignity and respect by making sure all RASPs and Assessments are the most up to date with current level of care needed for each resident starting 5/1/24 with the company's new assessment tool. A reeducation of all staff regarding the requirement that a resident shall be treated with dignity and respect will be conducted at the next monthly meeting on May 30th, 2024 by [redacted], EOO

Licensee's Proposed Overall Completion Date: *05/30/2024*

Not Implemented - 06/03/2024)

51 - Criminal Background Check

9. Requirements

2600.

51. Criminal History Checks - Criminal history checks and hiring policies shall be in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.101—10225.5102) and 6 Pa. Code Chapter 15 (relating to protective services for older adults).

Description of Violation

Staff person A, the home's a[redacted] was hired [redacted]23; however; his Pennsylvania State Police Criminal Background Check was completed 1/24/22.

Plan of Correction ***Accept[redacted] 05/10/2024)***

Staff person A was hired on [redacted]/22 as the Administrative Services Director. Upon a promotion on 8/8/24 to the Executive Operations Officer, Administrator, position, staff person A did not receive an additional background check. The immediate and corrective action taken by [redacted], Administrative Services Director, was an additional background check on staff person A completed on 3/12/24. Along with this, an initial and ongoing monthly auditing step, to include auditing all staff records to ensure a completed criminal history check is on file will be documented by [redacted] EOO that will begin on May 8th 2024.

The preventative action taken by [redacted], EOO is a requirement for all internal promotions to administrator starting 4/22/24 to have an additional background check upon promotional start date.

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented - 05/17/2024)

63a - First Aid/CPR Training

10. Requirements

2600.

63a - First Aid/CPR Training *(continued)*

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 2/10/24 from 10:30 p.m. to 2/11/24 at 6:30 a.m. there were 44 residents present in the home; however, there were no staff persons present in the home trained in first aid and certified in obstructed airway techniques and CPR.

On 2/12/24 from 10:30 p.m. to 2/13/24 at 7:00 a.m. there were 42 residents present in the home; however, there were no staff persons present in the home trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The immediate and corrective action taken by [redacted], EOO was CPR classes for team members to be current with their certifications. Classes on 2/23/24, 3/1/24, and 3/8/24 were conducted by [redacted]

An auditing step, to include daily, the schedule will be reviewed to ensure that at least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR is present in the home at all times. This will be completed at the beginning of each new schedule by [redacted] Resident Wellness Director starting with the next schedule on May 13th, 2024.

The preventative action conducted by [redacted], Executive Operations Officer and [redacted], Administrative Services Director, is a tracking system to ensure that there are no lapses in CPR certification starting 4/22/24.

Licensee's Proposed Overall Completion Date: *05/13/2024*

Not Implemented [redacted] - 05/17/2024)

65i - Training Record

11. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

The home has no documentation of resident right's training completed by staff 1/23/24.

Plan of Correction ***Accept[redacted] - 05/10/2024)***

There is no immediate or corrective action for the above violation due to the training being conducted on 1/23/24.

A ongoing monthly auditing step, to include auditing all staff records to ensure they contain documentation of all required staff training in accordance with 2600.65. These training documentation shall include: The staff person trained, date, source, content, length of each course and copies of any certificates. Documentation will be kept by [redacted], EOO. The initial audit will be on May 8th, 2024, and the begin date for ongoing monthly audits will start with the next monthly training scheduled for 5/30/24.

The preventative action taken by [redacted], Executive Operations Officer, will be have a log of attendance

65i - Training Record (continued)

for all future trainings starting on 4/24/24.

Licensee's Proposed Overall Completion Date: *05/30/2024*

Not Implemented ([redacted]/03/2024)

82c - Locking Poisonous Materials

12. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 2/13/24 At 11:10 a.m., a 40.5 fluid ounce container of Dial professional antibacterial liquid foaming handwash was unlocked, unattended, and accessible in the cabinet above the dishwasher in SDCU's kitchen. The manufacturer's label indicates, "If swallowed, get medical help or contact a Poison Control Center right away". Not all residents of the home, including resident #7, have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The immediate action was the removal of the 40.5 fluid ounce container of Dial professional antibacterial liquid foaming handwash from the unlocked cabinet by [redacted], Executive Operations Officer, on 2/13/24.

The corrective action of locking of the 40.5 fluid ounce container of Dial professional antibacterial liquid foaming handwash in the proper location, which was conducted by [redacted], EOO on 2/13/24.

The preventative action will be conducted by [redacted] Safety and Maintenance Engineer at the all-staff meeting in the form of a training that al poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials on 4/24/24.

Licensee's Proposed Overall Completion Date: *04/24/2024*

Implemented [redacted]/17/2024)

92 - Windows

13. 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 2/13/24, there was no screen in the right window of resident bedroom #102.

On 2/14/24. there was no screen in the 1st floor SDCU common area window at the end of the hall to the right.

Repeat Violation: 2/14/2023

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The immediate and corrective action taken by [redacted] afety and Maintenance Engineer, was the addition of a screen for the right window of resident bedroom 102 on 2/14/24. Also, an additional screen was added to the

92 - Windows (continued)

1st floor SDCU common area window at the end of the hall to the right by [redacted], Safety and Maintenance Engineer, on 2/14/24.

The preventative action taken by [redacted], EOO was the addition on a monthly check of the community's screens to the community's work order system, Tels starting 4/22/24. A weekly monitoring step of all areas of the home will be inspected to ensure all windows, including doors with windows, are in good repair, and all operable windows have screens that are securely attached and in good repair by [redacted], SME starting 5/13/24.

Licensee's Proposed Overall Completion Date: *05/13/2024*

Not Implemented ([redacted] - 05/17/2024)

101j7 - Lighting/Operable Lamp

14. 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 2/13/24, Resident #8 did not have access to a source of light that can be turned on/off at bedside.

Repeat Violation: 5/24/2023 et al, 2/14/2023

Plan of Correction ***Accept[redacted] - 05/10/2024)***

The immediate and corrective action taken by [redacted] Safety and Maintenance Engineer, was the addition of a source of light that can be turned on/off at bedside for Resident #8 on 2/14/24.

The preventative action taken by [redacted], EOO was the addition of a monthly facility inspection for all resident furniture and equipment to the community's work order system, Tels starting 4/22/24. A daily monitoring step completed by the Hospitality department, documented by [redacted], SME for resident bedrooms will be inspected to ensure residents have an operable lamp or other source of lighting that can be turned on/off at bedside. Any damaged or missing light sources discovered shall immediately be repaired or replaced starting 5/13/24.

Licensee's Proposed Overall Completion Date: *05/13/2024*

Not Implemented[redacted] - 05/17/2024)

103g - Storing Food

15. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 2/13/24 at 10:35 a.m., a bag of 4 frozen black bean burger patties was opened and not sealed in the main kitchen's walk-in freezer.

Plan of Correction ***Accept[redacted] - 05/01/2024)***

The immediate action taken was [redacted], [redacted], disposed on the bag of 4 frozen black bean burger patties that was opened and not sealed in the main kitchen's walk-in freezer on 2/13/24.

103g - Storing Food (continued)

The corrective action was [redacted] Director, labeled non-open frozen black bean burger patties on 2/13/24.

The preventative action taken by [redacted], is a training conducted on 4/24/24, at an all-staff meeting, regarding the importance and how to properly seal and label all food.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented [redacted] - 05/17/2024)

103i - Outdated Food

16. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 2/13/24, the following items were opened and resealed; however, were undated in the main kitchen's walk-in freezer:

* *A bag of chicken*
* *A bag of French fries*
* *A bag of corn*

On 2/13/24, the following items were opened and resealed; however, were undated in the main kitchen's dry storage room:

* *Yellow cake mix*
* *Devil's food cake mix*
* *Brownie mix*
* *Butterfinger mix*
* *Raspberry gelatin*

Plan of Correction ***Accept [redacted] - 05/01/2024)***

The immediate action taken was [redacted], disposed the bag of chicken, the bag of French fries, and the bag of corn on 2/13/24.

The corrective action was [redacted] labeled The Yellow cake mix, Devil's food cake mix, Brownie mix, Butterfinger mix, and Raspberry gelatin with their proper dates on 2/13/24.

The preventative action taken by [redacted] Director, is a training conducted on 4/24/24, at an all-staff meeting, regarding the importance and how to properly seal and label all food.

Licensee's Proposed Overall Completion Date: *04/22/2024*

Implemented [redacted] 05/17/2024)

132c - Fire Drill Records

17. Requirements

2600.

132c - Fire Drill Records *(continued)*

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 drills conducted on 11/30/23, 12/30/23 and 1/31/24 are not documented in military time and do not indicate AM or PM.

Repeat Violation: 5/24/23 et al, 2/14/2023

Plan of Correction ***Directed (- 05/13/2024)***

The immediate and corrective action was conducted by , Safety and Maintenance Engineer, was the addition AM and PM to the fire drill record and changing the time to military time on 2/15/24.

The preventative action and additional level of monitoring to prevent future violations taken by EOO is a monthly audit for each fire drill to be in compliance with 2600.132 starting 4/22/24. There will be an additional reeducation from Nathan Maietta, EOO to , SME on 5/8/24.

Proposed Overall Completion Date: 05/08/2024

Directed:
Beginning 5/15/24, the fire drill log will be audited by 2 staff immediately upon the conclusion of every fire drill, to ensure accurate documentation of 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. Documentation of audits will be kept.
5/13/24

Proposed Overall Completion Date: 05/13/2024
Proposed Overall Completion Date: 05/15/2024

Directed Completion Date: *05/15/2024*

Implemented /17/2024)

141b1 - Annual Medical Evaluation

18. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

On 2/13/24, resident #5's most recent medical evaluation was completed on 22.

Plan of Correction ***Accept - 05/10/2024)***

The corrective action taken by , Executive Operations Officer was a contract signed with a new Medical Director for a start date of 4/8/24 to ensure that all medical evaluations are up to date and signed.

141b1 - Annual Medical Evaluation (continued)

The preventative action taken by [redacted], Executive Operations Officer was a training on 4/23/24 with [redacted], Resident Wellness Director on medical evaluations and their signatures. Also, on 4/23/24 the preventative action of a spreadsheet tracking system was created by and will be maintained by [redacted], Resident Wellness Director for all current residents' medical evaluation dates. An additional ongoing monthly auditing step, to include auditing resident records to ensure an in-person medical evaluation has been conducted within the past year and is present in all resident files will be completed by [redacted] Resident Wellness Director starting 5/8/24.

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted] - 05/17/2024)

185a - Implement Storage Procedures

19. 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

On 2/13/24, resident #8's glucometer was not calibrated to the current date and time.

Plan of Correction ***Accept[redacted] 05/10/2024)***

The immediate and corrective action taken by [redacted] Wellness Director on 2/13/24 was to calibrate to the current date and time on resident #8's glucometer.

An initial and ongoing monthly auditing action, to include auditing all resident glucometers to ensure they are calibrated to the correct date and time will be conducted by [redacted] starting on May 8th, 2024.

The preventative action taken by [redacted], Resident Wellness Director is a training for all wellness team members on the importance of safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons at the monthly meeting on 4/24/25

Licensee's Proposed Overall Completion Date: *05/08/2024*

Not Implemented [redacted]/17/2024)

187a - Medication Record

20. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

1. Resident’s name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.
8. Frequency of administration.
9. Administration times.
10. Duration of therapy, if applicable.

187a - Medication Record *(continued)*

11. Special precautions, if applicable.
12. Diagnosis or purpose for the medication, including pro re nata (PRN).
13. Date and time of medication administration.
14. Name and initials of the staff person administering the medication.

Description of Violation

Resident #5's February 2024 medication administration record (MAR) does not indicate the diagnosis for the following medications:

* *Doxycycline 100mg*
* *Quetiapine 50mg by*

Resident #9's February 2024 MAR does not indicate the diagnosis for the following medications:

* *Olanzapine 2.5mg*
* *Oyster shell Calcium 500mg + Vitamin D 400mg*
* *Quinapril 40mg*
* *Vitamin D2 50,000 Units capsules*

Plan of Correction [redacted] ***- 05/10/2024)***

The immediate and corrective action was the addition of an indication of diagnosis for Resident #5's medications; Doxycycline 100mg and Quetiapine 50mg by Polaris Pharmacy in our EMAR System, Quick MAR. Also, the addition of an indication of diagnosis for Resident #9's medications; Olanzapine 2.5mg, Oyster shell Calcium 500mg + Vitamin D 400mg, Quinapril 40mg, Vitamin D2 50,000 Units capsules by Polaris Pharmacy in our EMAR System, Quick MAR.

An initial and ongoing monthly auditing step completed by [redacted]*, RWD includes auditing all resident MARs to ensure all diagnoses are present. The initial audit will be completed by 6/1/24 and will continue monthly following the completion of the initial audit.*

The preventative action will be the addition of diagnosis next to every medication by Polaris Pharmacy in our EMAR System, Quick MAR starting 4/22/24.

Licensee's Proposed Overall Completion Date: *06/01/2024* ***Not Implemented*** [redacted] ***- 06/03/2024)***

187c - Refusal of Medication

21. Requirements

2600.
187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

From 12/30/23 - 2/15/24, resident #10 refused Acetaminophen tablet 325mg and Ibuprofen tablet 600mg multiple times. However, the home does not have documentation they notified the prescriber of these refusals.

187c - Refusal of Medication *(continued)*

Plan of Correction ***Directed [redacted] - 05/13/2024)***

The is no immediate or corrective action as Resident #10's original prescriber is no longer [redacted] physician.

The preventative action taken by [redacted] starting on 4/23/24 was that all refusals of medication will result in a report to the prescriber/provider within 24 hours of the refusal. Refusals will be monitored and documented through the community's EMAR system, QuickMAR.

A reeducation step, to include reeducating all staff qualified to administer medication that the resident has a right to question or refuse medication if they believe there is a medication error, in accordance with 2600.191. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber, in accordance with 2600.187b. This reeducation will be conducted by [redacted] RWD on 5/31/24 at the next monthly Wellness team meeting.

Proposed Overall Completion Date: 05/31/2024

Directed:
By 5/15/24 and weekly thereafter, the administrator or designee qualified to administer medication, will monitor refusals through QuickMAR. Documentation of monitoring will be kept.
[redacted] ***13/24***

Proposed Overall Completion Date: 05/15/2024

Directed Completion Date: *05/31/2024*

Not Implemented [redacted] - 06/03/2024)

187d - Follow Prescriber's Orders

22. Requirements

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

Description of Violation

Resident #8 is prescribed Insulin Lisp 100 unit/ml - inject per sliding scale before meals and at bedtime:
<140= 0 units
141-180 = 1 unit
181-220 = 2 units
221-260 = 3 units
261- 300= 4 units
301- 340= 5 units
>361 = 6 units and call MD.
On 2/1/24, resident #8's blood glucose level was not measured before lunch.

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

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The preventative action that [redacted] is a training with all wellness staff to be conducted on 4/24/24 at their monthly meeting on follow the directions of the prescriber specific to Resident #8's blood glucose levels being measured appropriately.

A monitoring step weekly for 1 month then monthly for 3 months, [redacted] RWD or [redacted], EOO will observe each staff person responsible for diabetic care perform blood glucose checks to ensure blood glucose readings are accurately documented on the resident MAR and Insulin, to include sliding scale, is administered according to the directions of the prescriber and properly documented on the resident MAR. Documentation will begin on 5/13/24.

Licensee's Proposed Overall Completion Date: *05/13/2024*

Implemented [redacted] - 05/17/2024)

225a - Assessment 15 Days

23. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #8's initial assessment, dated [redacted]23, does not include the diagnoses of Diabetes, HDCM, Debility, Memory Deficits, Urinary Incontinence, IBS, Lumbar Stenosis, Hyperthyroidism and HTN as indicated on the resident's initial medical evaluation, dated 1/31/23.

Resident #11's initial assessment, dated [redacted]/23, does not include the diagnoses of Essential Hypertension, Impaired Glucose Tolerance, Atrial Fibrillation, Type 1 Diabetes, Paroxysmal Atrial Fibrillation, Obstructive Sleep apnea, Osteoarthritis of multiple joints, Diabetic Retinopathy, Left Hip Pain, Mixed Obstructive Lung Disease, Hypoxia, Pseudophakia, Cystoid macular edema right eye, Uveitis-hyphemia glaucoma syndrome left eye, and Diabetic Macular Edema as indicated on the resident's initial medical evaluation, dated 9/4/23.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The immediate and corrective action taken by Resident Wellness Associate, Alyssa Silvis was the addition of the diagnoses of Diabetes, HDCM, Debility, Memory Deficits, Urinary Incontinence, IBS, Lumbar Stenosis, Hyperthyroidism and HTN as indicated on the resident's initial medical evaluation, dated 1/31/23 for Resident #8's most recent RASP on 4/10/24. Along with this, Resident Wellness [redacted] added the diagnoses of Essential Hypertension, Impaired Glucose Tolerance, Atrial Fibrillation, Type 1 Diabetes, Paroxysmal Atrial Fibrillation, Obstructive Sleep apnea, Osteoarthritis of multiple joints, Diabetic Retinopathy, Left Hip Pain, Mixed Obstructive Lung Disease, Hypoxia, Pseudophakia, Cystoid macular edema right eye, Uveitis-hyphemia glaucoma syndrome left eye, and Diabetic Macular Edema as indicated on the resident's initial medical evaluation, dated 9/4/23 to Resident #11's most recent RASP on 4/10/24.

The preventative action performed by Resident Wellness Associate, [redacted] is the creation of a tracker for all assessments starting on 4/23/24.

225a - Assessment 15 Days (continued)

An initial and then monthly auditing of all resident records to ensure an assessment is completed, accurate and present in each resident record will be completed by [redacted] RWD. The initial audit will be completed by 6/1/24 and then will follow monthly following the initial audit completion.

Licensee's Proposed Overall Completion Date: *06/01/2024* ***Not Implemented [redacted] - 06/03/2024)***

225c - Additional Assessment

24. 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 #1's assessment, dated [redacted]/23, does not include the resident's use of a Care Predict (Tempo)- wander guard/fall watch.

From 11/21/23 - 1/3/24, resident #1 experienced 6 falls, resulting in changes in [redacted] ability to transfer in and out of bed, mobility, irritability, judgement, agitation, communication of needs, cognition, wandering, and anxiety. However, [redacted] assessment, dated [redacted]/23, was not updated to reflect these changes.

Resident #6's assessment, dated [redacted]/23, does not include the diagnosis of depression, as indicated on [redacted] medical evaluation, dated [redacted]/23.

Resident #6's assessment, dated [redacted]/23, was not updated to address the resident's behavioral changes including taking food from other residents, invading other residents' person space, and creating instances of physical altercations.

Resident #7's assessment, dated [redacted]/23, was not updated to address the resident's behavioral changes including aggression, agitation, irritability.

Plan of Correction ***Accept [redacted] - 05/10/2024)***

There was no immediate action taken for Resident #1 due to [redacted] moving out of the facility before the DHS inspection began. The Immediate action for Resident #6 was the addition of a depression diagnosis as well as the resident's behavioral changes including taking food from other residents, invading other residents' person space to their RASP by [redacted] starting 4/10/24. The immediate action taken for Resident #7 was the addition of the resident's behavioral changes including aggression, agitation, and irritability to their RASP by [redacted] Wellness Director starting 4/10/24.

An initial and monthly auditing step to include auditing all resident records to ensure assessments are completed, accurate and present in each resident record. Documentation will be kept by [redacted] and the initial audit will be completed by 6/1/24. Monthly Audits will begin 7/1/24, the following month after the initial audit has been completed.

225c - Additional Assessment (continued)

The corrective action taken by [redacted] *Wellness Director was that all residents shall have additional assessments if the condition of the resident significantly changes starting 4/10/24. Along with this, an additional corrective action taken by the community's Resident Wellness Director,* [redacted] *change the support plan to indicate the services being provided when a significant change occurs if the condition requires an additional service to be provide by the facility or another organization starting 4/10/24.*

The preventative action taken by Executive Operations Officer, [redacted] *was educational training for Resident Wellness Director,* [redacted] *on the importance of the indication of services on assessments and support plans was conducted on 4/23/24.*

Licensee's Proposed Overall Completion Date: *06/01/2024*

Not Implemented [redacted] ***- 06/03/2024)***

231c - Preadmission Screening

25. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #9 was admitted to the SDCU on [redacted] *22; however, the resident's written cognitive preadmission screening was completed on 7/5/22.*

Plan of Correction ***Accept*** [redacted] ***05/10/2024)***

An initial and monthly auditing step to include auditing all SDCU resident records to ensure a written cognitive preadmission screening form is completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form within 72 hours prior to admission to the SDCU will be conducted by [redacted] *Wellness Director Starting 5/6/24.*

The preventative action taken by [redacted] *Resident Wellness Director starting on 4/23/24 is that all residents will be given a written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.*

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented [redacted] ***- 05/17/2024)***

251b - Record Entries Legible

26. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid covered resident #4's signature on transactions dated 10/20/23 and 12/1/23 on resident #4's Resident Personal Cash Tracking form.

251b - Record Entries Legible *(continued)*

Plan of Correction ***Accept [redacted] - 05/10/2024)***

The immediate and corrective action was a new form used for the entries in a resident #4's record for their Resident Personal Cash Tracking form by [redacted]. In addition to this action, a monthly audit of all Resident Personal Cash tracking forms will be conducted, to ensure entries are permanent, legible, dated and signed by the staff person making the entry. This will be completed by [redacted], Administrative Services Director Starting 5/1/24.

Starting on 4/23/24 [redacted] will ensure that all Resident Personal Cash Tracking forms will be free of correctional fluid to not cover any signatures or transitions.

Licensee's Proposed Overall Completion Date: *05/06/2024*

Not Implemented [redacted] - 05/17/2024)