

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

April 29, 2024

[REDACTED]  
BALL PAVILION INC  
[REDACTED]  
[REDACTED]

RE: BARNABAS COURT AT BREVILLIER  
VILLAGE  
5416 EAST LAKE ROAD  
ERIE, PA, 16511  
LICENSE/COC#: 45306

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/26/2024, 01/31/2024, 02/12/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: BARNABAS COURT AT BREVILLIER VILLAGE License #: 45306 License Expiration: 12/08/2024  
Address: 5416 EAST LAKE ROAD, ERIE, PA 16511  
County: ERIE Region: WESTERN

**Administrator**

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

**Legal Entity**

Name: BALL PAVILION INC  
Address: [Redacted]  
Phone: [Redacted] Email: [Redacted]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 11/16/1989 Issued By: Dept. of Labor & Industry  
Type: I-2 Date: 02/22/2018 Issued By: Harborcreek Township

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 97 Waking Staff: 73

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Incident Exit Conference Date: 02/12/2024

**Inspection Dates and Department Representative**

01/26/2024 - On-Site: [Redacted]  
01/31/2024 - Off-Site: [Redacted]  
02/12/2024 - Off-Site: [Redacted]

**Resident Demographic Data as of Inspection Dates**

General Information			
License Capacity:	120	Residents Served:	58
Secured Dementia Care Unit			
In Home:	Yes	Area:	Barnabus Court North
Capacity:	60	Residents Served:	38
Hospice			
Current Residents:	1		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	58
Diagnosed with Mental Illness:	3	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	39	Have Physical Disability:	0

**Inspections / Reviews**

01/26/2024 - Partial

Lead Inspector: [Redacted] Follow-Up Type: POC Submission Follow-Up Date: 03/15/2024

Inspections / Reviews *(continued)*

03/26/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/11/2024

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 04/02/2024

04/04/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/11/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/11/2024

04/29/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/11/2024

Reviewer: [REDACTED]

Follow-Up Type: Not Required

## 42b - Abuse

## 1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

**Description of Violation**

Resident [REDACTED] assessment and support plan, dated [REDACTED], indicates diagnoses of [REDACTED], major [REDACTED] [REDACTED], and [REDACTED]. Resident [REDACTED] was prescribed [REDACTED], give [REDACTED] tablet by mouth 2 times per day for [REDACTED]. However, this medication was discontinued by the resident's physician on [REDACTED], as [REDACTED] suffered a fall without injury. From 1/3/24 to 1/22/24, resident [REDACTED] daily asked staff to contact [REDACTED] physician for another [REDACTED] medication. Staff indicate they have never seen a resident so tortured by [REDACTED] like resident [REDACTED]. Despite the resident's numerous and repeated requests, no medication for [REDACTED] was prescribed.

On [REDACTED], staff person A found resident [REDACTED] in [REDACTED] bedroom, rocking back and forth and with garbled speech. Resident [REDACTED] told staff person A [REDACTED] took a half bottle of [REDACTED], which was in [REDACTED] bedroom, because [REDACTED] was trying to feel better and did not want to live life anymore because staff and [REDACTED] doctor are not helping [REDACTED]. Resident [REDACTED] was sent to the emergency room and was found to have no adverse effects from the ingested medication.

On [REDACTED] resident [REDACTED] was discharged from the hospital into the home's secure dementia care unit (SDCU). Resident [REDACTED] does not have a diagnosis of [REDACTED] disease or other dementia. Although resident [REDACTED] signed a "Voluntary Residency in a Secure Dementia Unit" form, resident [REDACTED] stated [REDACTED] does not want to live in the SDCU but was not able to go back to [REDACTED] old bedroom until [REDACTED] does better. From 1/24/24 - 1/27/24, resident [REDACTED] was denied access to [REDACTED] bedroom in the PCH section of the home.

**Plan of Correction**

Accept [REDACTED] - 04/04/2024)

After medication overdose incident occurred on the morning of [REDACTED], Resident [REDACTED] was sent to St. Vincent Hospital and was voluntarily admitted to Mental Health Intake Unit. St. Vincent hospital called PCHA on 1/24/24 and informed facility that Resident [REDACTED] was not deemed to be in danger of harming [REDACTED] or others so [REDACTED] could not stay at the hospital or receive anymore mental health services there.

On [REDACTED], Social Workers completed a room search of Resident [REDACTED] bedroom at PCH (South Room [REDACTED] with permission of Resident [REDACTED] and Resident [REDACTED] POA. Several expired and unmarked medications were found and removed from room, as resident [REDACTED] is not a self-medicating resident. Effective [REDACTED] Social Worker and/or PCHA will complete room audit every month to ensure Resident [REDACTED] is not keeping unsecured/unlabeled medications in [REDACTED] room.

Resident [REDACTED] was admitted to SDCU on the evening [REDACTED] with a short-term lease at the discretion of the PCHA. PCHA wanted to ensure resident's safety until a determination of [REDACTED] mental health status could be witnessed by facility staff, and she could be seen by her PCP.

On 1/25/24, Director of Nursing and PCHA met with all nurses who work in PCH. Meeting minutes are attached for material that was reviewed. Medication Administration policies and procedures were discussed and reviewed with all PCH nurses.

DON will set up educational in-service with Pharmacy for proper medication administration. This training was held on 3/12/24 by the DON. Meeting Handouts are attached.

42b - Abuse (continued)

As of 2/6/24, an additional nurse shift from 6-10pm daily will be added to ensure resident medication administration policies and procedures are being followed. This was scheduled by the DON and will be ongoing.

Resident [redacted] was seen by PCP on 1/26/24. PCP wrote a new order for anxiety medication ([redacted]) to be given 2 times daily. PCP also recommended follow up appointments with a Psychiatrist, Neurologist, Neurosurgeon, and Neuropsychologist. These follow up appointments were scheduled by the Social Worker and Medical Secretary.

Resident [redacted] was seen on [redacted] by [redacted], Neuropsychologist, for counseling on this date and will be ongoing.

Resident [redacted] was seen on [redacted] by [redacted], the Neurosurgeon who completed [redacted] shunt procedure months prior, for a follow up appointment.

Resident [redacted] was seen by [redacted], Neurologist, on [redacted] for a check up. Follow up scheduled every six months.

Resident [redacted] was seen by a new Psychiatrist, [redacted] on [redacted]. [redacted] ordered new medication for depression and will follow up on 4/11/24.

Resident [redacted] moved back to her original room at PCH (Barnabas Court South) on Saturday, [redacted], per [redacted] request. PCHA and Social Workers assisted with this move. Along with Resident [redacted] PCHA cleared resident's room of more unmarked/unlabeled medications on 1/27/24.

Social Worker reviewed PCH Medication Policy with Resident [redacted] on [redacted]. Resident understands [redacted] cannot keep unmarked/unlabeled medications in [redacted] room and [redacted] medications need to be administered per facility policies.

Effective immediately after incident, Nursing staff, Social Worker, and PCHA will offer extra support for Resident on an ongoing basis. Resident's POA also made arrangements for a private duty caregiver to come in weekly for socialization and assistance one-on-one with resident. This started on 1/30/24 and will be ongoing on a weekly basis to offer resident extra companionship and support.

UPDATE: Resident [redacted] and [redacted] POA gave permission for monthly room audits upon [redacted] return to [redacted] room at PCH on Saturday, January, [redacted]

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

Implemented [redacted] - 04/29/2024)

101i - Access to Bedroom

2. Requirements

2600.

101.i. A resident shall have access to his bedroom at all times.

Description of Violation

Resident [redacted] assessment and support plan, dated [redacted], indicates diagnoses of [redacted], major [redacted], [redacted], and [redacted]. Resident [redacted] was prescribed [redacted], give [redacted] tablet by mouth 2 times per day for [redacted]. However, this medication was discontinued by the resident's physician on [redacted] as [redacted] suffered a fall without injury. From 1/3/24 to 1/22/24, resident [redacted] daily asked staff to contact [redacted] physician for another anxiety medication. Staff indicate they have never seen a resident so tortured by [redacted] like resident [redacted]. Despite the

**101i - Access to Bedroom (continued)**

resident's numerous and repeated requests, no medication for anxiety was prescribed.

On [REDACTED], staff person A found resident [REDACTED] in [REDACTED] bedroom, rocking back and forth and with garbled speech. Resident [REDACTED] told staff person A [REDACTED] took a half bottle of [REDACTED], which was in [REDACTED] bedroom, because [REDACTED] was trying to feel better and did not want to live life anymore because staff and [REDACTED] doctor are not helping [REDACTED]. Resident [REDACTED] was sent to the emergency room and was found to have no adverse effects from the ingested medication.

On [REDACTED], resident [REDACTED] was discharged from the hospital into the home's SDCU. Resident [REDACTED] does not have a diagnosis of [REDACTED] disease or other [REDACTED]. Although resident [REDACTED] signed a "Voluntary Residency in a Secure Dementia Unit" form, resident [REDACTED] stated [REDACTED] does not want to live in the SDCU but was not able to go back to [REDACTED] old bedroom until [REDACTED] does better. From 1/24/24 - 1/27/24, resident [REDACTED] was denied access to [REDACTED] bedroom in the PCH section of the home.

**Plan of Correction**

Accept [REDACTED] - 03/26/2024)

On [REDACTED] Resident [REDACTED] was taken to [REDACTED] room at South by a Social Worker to retrieve additional personal items for her planned short-term stay at the SDCU room.

PCHA and Social Worker met with Resident on [REDACTED] to discuss moving back to original room in PCH.

Resident [REDACTED] moved back to her original room at PCH (Barnabas Court South) on Saturday, [REDACTED] per [REDACTED] request. PCHA and Social Workers assisted with this move. Along with Resident [REDACTED] PCHA cleared resident's room of more unmarked/unlabeled medications on [REDACTED]

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented [REDACTED] - 04/29/2024)

**183a - Original Containers and Injections****3. Requirements**

2600.

183.a. Prescription medications, OTC medications and CAM shall be kept in their original labeled containers and may not be removed more than 2 hours in advance of the scheduled administration. Assistance with insulin and epinephrine injections and sterile liquids shall be provided immediately upon removal of the medication from its container.

**Description of Violation**

Resident [REDACTED] is prescribed multiple medications to be administered at various times throughout the day. For approximately 1 year, staff person B and staff person C removed these medications from their original labeled containers, and provided the medications in a cup at 8:00 a.m. to resident [REDACTED] to administer independently throughout the day. Resident [REDACTED] medical evaluations, dated 11/2/23 and 1/26/23, indicate the resident cannot self-administer medications.

**Plan of Correction**

Accept [REDACTED] - 04/04/2024)

On 1/25/24, Director of Nursing and PCHA met with all nurses who work in PCH. Meeting minutes are attached for material that was reviewed. Medication Administration policies and procedures were discussed and reviewed with all PCH nurses.

DON will set up educational in-service with Pharmacy for proper medication administration. This training was held

**183a - Original Containers and Injections (continued)**

on 3/12/24 by the DON. Meeting Handouts are attached.

As of 2/6/24, an additional nurse shift from 6-10pm daily will be added to ensure resident medication administration policies and procedures are being followed. This will be scheduled by the DON and will be ongoing.

**UPDATE:**

Effective 3/15/24, DOH and/or PCHA will perform monthly audits of Nurse med pass. This will be ongoing effective 3/15/24.

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

Implemented [REDACTED] - 04/29/2024)

**183b - Meds and Syringes Locked****4. Requirements**

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

**Description of Violation**

On [REDACTED], a bottle of [REDACTED] was unlocked, unattended, and accessible in resident [REDACTED] bedroom. On [REDACTED], staff person A found resident [REDACTED] in [REDACTED] bedroom, rocking back and forth and with garbled speech. Resident [REDACTED] told staff person A [REDACTED] took a half bottle of [REDACTED], because [REDACTED] was trying to feel better and did not want to live life anymore because staff and [REDACTED] doctor are not helping [REDACTED]. Resident [REDACTED] was sent to the emergency room and was found to have no adverse effects from the ingested medication.

**Plan of Correction**

Accept [REDACTED] - 04/04/2024)

On [REDACTED] Social Workers completed a room search of Resident [REDACTED] bedroom at PCH (South Room [REDACTED] with permission of Resident [REDACTED] and Resident [REDACTED] POA. Several expired and unmarked medications were found and removed from room, as resident [REDACTED] is not a self-medicating resident.

Effective 1/24/24, Social Worker and/or PCHA will complete room audit every month to ensure Resident [REDACTED] is not keeping unsecured/unlabeled medications in [REDACTED] room.

On 1/25/24, Director of Nursing and PCHA met with all nurses who work in PCH. Meeting minutes are attached for material that was reviewed. Medication Administration policies and procedures were discussed and reviewed with all PCH nurses.

Social Worker reviewed PCH Medication Policy with Resident [REDACTED] on 1/27/24. Resident understands [REDACTED] cannot keep unmarked/unlabeled medications in [REDACTED] room and [REDACTED] medications need to be administered per facility policies.

**UPDATE:**

Effective 3/15/24, DOH and/or PCHA will perform monthly audits of Nurse med pass. This will be ongoing effective 3/15/24.

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

Implemented [REDACTED] - 04/29/2024)

187b - Date/Time of Medication Admin.

5. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed multiple medications to be administered at various times throughout the day. For approximately 1 year, staff person B and staff person C removed these medications from their original labeled containers, and provided the medications in a cup at 8:00 a.m. to resident [REDACTED] to administer independently throughout the day. However, staff person B and staff person C documented administration of these medications on resident [REDACTED] medication administration record at 7:00a.m., 8:00a.m., 11:00a.m., 2:00p.m., 3:00p.m., and 5:00p.m., to include the following:

[REDACTED] give 2 tablets by mouth 4 times per day 8:00a.m, 11:00a.m, 2:00p.m., 5:00p.m.

[REDACTED] in the morning 8:00a.m., afternoon 2:00p.m., and evening, 5:00p.m. [REDACTED], give 1 tablet by mouth 2 times daily 7:00a.m., 3:00p.m.

Plan of Correction

Accept [REDACTED] 03/26/2024)

On 1/25/24, Director of Nursing and PCHA met with all nurses who work in PCH. Meeting minutes are attached for material that was reviewed. Medication Administration policies and procedures were discussed and reviewed with all PCH nurses.

DON set up educational in-service with Pharmacy for proper medication administration. This training was held on 3/12/24 by the DON. Meeting Handouts are attached.

As of 2/6/24, an additional nurse shift from 6-10pm daily will be added to ensure resident medication administration policies and procedures are being followed. This was will be scheduled by the DON and will be ongoing.

Effective 3/15/24, DOH and/or PCHA will perform monthly audits of Nurse med pass. This will be ongoing effective 3/15/24.

Licensee's Proposed Overall Completion Date: 03/15/2024

Implemented [REDACTED] - 04/29/2024)

187d - Follow Prescriber's Orders

6. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed multiple medications to be administered at various times throughout the day. For approximately 1 year, staff person B and staff person C removed these medications from their original labeled containers, and provided the medications in a cup at 8:00 a.m. to resident [REDACTED] to administer independently throughout the day, to include the following:

[REDACTED] give [REDACTED] tablets by mouth 4 times per day 8:00a.m, 11:00a.m, 2:00p.m., 5:00p.m.

[REDACTED], give [REDACTED] in the morning 8:00a.m., afternoon 2:00p.m., and evening, 5:00p.m.

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

████████████████████, give 1 tablet by mouth 2 times daily 7:00a.m., 3:00p.m.

**Plan of Correction****Accept** ██████████ **03/26/2024)**

PCHA met with PCP, ██████████, on Friday, ██████████ to discuss the sensitivity of Resident ██████████ incident. PCP reviewed and made changes to resident ██████████ medication list on ██████████. PCH Nurses were made aware of medication changes and the specific need to administer Resident ██████████ medications on time.

DON and PCHA educated and reviewed proper medication administration procedures with all PCH nurses at a meeting on 1/25/24. This meeting was scheduled previous to incident, but all PCH nurses were in attendance.

Effective 3/15/24, DON and/or PCHA will perform monthly audits of Nurse med pass. This will be ongoing effective 3/15/24.

**Licensee's Proposed Overall Completion Date: 03/15/2024**

**Implemented** ██████████ **- 04/29/2024)**