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

July 8, 2024

[redacted]
MENTOR ABI LLC
[redacted]

RE: NEURORESTORATIVE
PENNSYLVANIA
6816 WEST LAKE ROAD
FAIRVIEW, PA, 16415
LICENSE/COC#: 44710

[redacted] ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/22/2024 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: *NEURORESTORATIVE PENNSYLVANIA* **License #:** *44710* **License Expiration:** *11/05/2024*

Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA 16415*

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

Administrator

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

Legal Entity

Name: *MENTOR ABI LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff: **Total Daily Staff:** *11* **Waking Staff:** *8*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date:** *02/22/2024*

Inspection Dates and Department Representative

02/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *8* **Residents Served:** *7*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *4* **Are 60 Years of Age or Older:** *0*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability:** *1*

Have Mobility Need: *4* **Have Physical Disability:** *7*

Inspections / Reviews

02/22/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/23/2024*

04/01/2024 - POC Submission

Submitted By: [redacted] **Date Submitted:** *04/09/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *04/08/2024*

Inspections / Reviews *(continued)*

04/09/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *04/09/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/24/2024*

07/08/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *04/09/2024*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

142c - Consent for Treatment

2. Requirements

2600.
142.c. If a resident has a serious medical or dental condition, reasonable efforts shall be made to obtain consent for treatment from the resident or the resident's designated person.

Description of Violation

Resident [redacted] had an unwitnessed fall on [redacted] between the times of [redacted] to [redacted] The fall resulted in resident [redacted] having a bloody nose and a fractured nasal bone. Resident [redacted] received no in house medical care/assistance until approximately [redacted] Resident [redacted] designated person was not contacted until [redacted], resident [redacted] not receive the provision of outside medical services until [redacted], at approximately [redacted] at Millcreek Community Hospital.

Plan of Correction ***Accept [redacted] - 04/09/2024)***

The staff member was removed from the floor at the time of discovery pending investigation; the staff has since been terminated.
A falls procedure and checklist were created by [redacted] on [redacted] and [redacted] on [redacted] the team was educated on the new procedure on [redacted] by [redacted]
The program began reviewing falls on the daily stand up following the checklist on 3.8.24. The checklist is reviewed with the on-call to ensure none of the steps were missed. The checklists are sent to the team after completion and saved in the file.
The staff members last day worked was [redacted], [redacted] was suspended by the Program Director. The staff member was terminated on [redacted].

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

Implemented [redacted] 07/08/2024)

187a - Medication Record

3. Requirements

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

Description of Violation

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on [redacted] [redacted] However, medication's non administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The field was blank.

Resident [redacted] is prescribed [redacted] capsule one cap by mouth every day. The resident was not administered this medication on [redacted], at [redacted]. However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The field was blank.

Resident [redacted] prescribed [redacted] 2 caps by mouth twice daily. The resident was not administered this medication on [redacted], at [redacted]., and at [redacted] However, the medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The field was blank.

Resident [redacted] is prescribed [redacted] tablet two tabs by mouth twice daily. The resident was not

187a - Medication Record (continued)

administered the medication on [redacted], at [redacted] However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and time. The field was blank.

Resident[redacted] is prescribed [redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on [redacted], at [redacted] and [redacted] However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The fields were blank.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on[redacted], at 4:00 p.m., and 8:00 p.m. However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The fields were blank.

President [redacted]is prescribed [redacted] two tabs by mouth every day. The resident was not administered this medication on[redacted], at [redacted] However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and time. The field was blank.

Resident [redacted] is prescribed [redacted] daily doses[redacted] / 1 dose powder[redacted] in 8 ounces of liquid by mouth twice daily. The resident was not administered this medication on[redacted] at[redacted]. However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and time. The field was blank.

Resident [redacted]is prescribed [redacted] tablets [redacted] by mouth three times daily. The resident was not administered this medication on [redacted], at [redacted]., and[redacted].m. However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and times. The fields were blank.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on [redacted], at [redacted] However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and time. The field was blank.

Resident[redacted] is prescribed [redacted] tablet take one tablet by mouth every night. The resident was not administered this medication. On [redacted], at[redacted]. However, medication's non-administration was not indicated on the resident's February 2024, mediation administration record for the corresponding date and time. The field was blank.

Plan of Correction ***Accept[redacted] - 04/09/2024)***

All Med Techs were assigned training "Right Documentation" by [redacted] on [redacted]; this is to be completed in Relias by [redacted].

The program will complete MAR reviews following all med passes. For any medications not passed, the supervisor or on-call will call the staff of the home to determine why the documentation hasn't been completed. Additionally, the DON will continue running daily audit reports and reviewing them with the supervisors every morning. The MAR reviews will begin on [redacted]and will be completed by the Supervisors.

All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The Quality Improvement Specialist completes an annual analysis of all med

187a - Medication Record (continued)

errors in October of each year. The team also meets the Executive team every other Wednesday to review med errors.

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

Implemented [redacted] - 07/08/2024)

188b - Medication Error Reporting

5. Requirements

2600.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

Description of Violation

Resident[redacted] is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on[redacted] [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] capsule one cap by mouth every day. The resident was not administered this medication on [redacted], at [redacted]. However, the home failed to notify the resident's designated person.

Resident[redacted] prescribed [redacted]capsule 2 caps by mouth twice daily. The resident was not administered this medication on [redacted], at [redacted] and at [redacted]. However, the home failed to notify the resident's designated person.

Resident [redacted] [redacted]is prescribed [redacted] tablet two tabs by mouth twice daily. The resident was not administered this medication [redacted], at[redacted]. However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on [redacted] at [redacted] and [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted]is prescribed[redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on[redacted], at [redacted] and [redacted] However, the home failed to notify the resident's designated person.

President [redacted] is prescribed [redacted] tablets two tabs by mouth every day. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted]is prescribed [redacted] daily doses [redacted]/ 1 dose powder [redacted] 8 ounces of liquid by mouth twice daily. The resident was not administered this medication on [redacted]at [redacted]. However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] tablets[redacted] tab by mouth three times daily. The resident was not administered this medication on [redacted], at [redacted] and [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted]is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not

188b - Medication Error Reporting (continued)

administered this medication on [redacted] at [redacted] . However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] tablet take one tablet by mouth every night. The resident was not administered this medication on [redacted] at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] capsule one cap by mouth twice daily. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] pen inject [redacted] subcutaneously at bedtime. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed or [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on [redacted] at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] tablet tab 1 tab by mouth twice daily. The resident was not administered this medication on [redacted] at [redacted] However, the home failed to notify the resident's designated person.

Resident [redacted] is prescribed [redacted] outer [redacted] inject as per sliding scale if [redacted], subcutaneously before meals and at bedtime related to type 2 diabetes. The resident's blood glucose levels were not measured on [redacted] at [redacted] and [redacted]. However, the home failed to notify the resident's designated person.

Plan of Correction ***Accept [redacted] - 04/09/2024)***

A Med Error Procedure how to was created by [redacted] on; the team was educated on the new procedure on [redacted] by [redacted]. A checklist to go with it was created by [redacted] on [redacted]
The program began reviewing med error process on the daily stand up utilizing the checklist on [redacted] The checklist is reviewed with the on-call to ensure none of the steps were missed. The checklists are sent to the team after completion and saved in the file.
All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The Quality Improvement Specialist completes an annual analysis of all med errors in October of each year. The team also meets the Executive team every other Wednesday to review med errors.

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

Implemented [redacted] - 07/08/2024)

188c - Medication Error Documentation

6. Requirements

2600.
188.c. Documentation of medication errors and the prescriber's response shall be kept in the resident's record.

188c - Medication Error Documentation *(continued)*

Description of Violation

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on [redacted], [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] capsule one cap by mouth every day. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] prescribed [redacted] 2 caps by mouth twice daily. The resident was not administered this medication on [redacted], at [redacted] and at [redacted]m. However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet two tabs by mouth twice daily. The resident was not administered this medication [redacted], at [redacted]. However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on [redacted], at [redacted] and [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth three times daily. The resident was not administered this medication on [redacted] at [redacted] and [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablets two tabs by mouth every day. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] daily doses [redacted] / 1 dose powder [redacted] in [redacted] ounces of liquid by mouth twice daily. The resident was not administered this medication on [redacted] at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablets [redacted] tab by mouth three times daily. The resident was not administered this medication on [redacted], at [redacted] and [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet 1 tab by mouth every day. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet take one tablet by mouth every night. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] capsule one cap by mouth twice daily The resident was not administered this medication on [redacted], at [redacted]. However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] / [redacted] pen inject [redacted] units subcutaneously at bedtime. The resident was not administered this medication on 2/7/2024 at 8:00 p.m. However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed or [redacted] tablet 1 tab by mouth every day. The resident was not

188c - Medication Error Documentation (continued)

administered this medication on [redacted] at [redacted] m. However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] tablet tab 1 tab by mouth twice daily. The resident was not administered this medication on [redacted], at [redacted] However, the home failed to document the prescriber's response.

Resident [redacted] is prescribed [redacted] outer [redacted] unit/[redacted] mill pen inject as per sliding scale if [redacted], subcutaneously before meals and at bedtime related to type [redacted] diabetes. The resident's blood glucose levels were not measured on [redacted] at [redacted]. and [redacted] However, the home failed to document the prescriber's response.

Plan of Correction ***Accept [redacted] - 04/09/2024)***

A Med Error Procedure how to was created by [redacted] on; the team was educated on the new procedure on [redacted] by [redacted]. A checklist to go with it was created by [redacted] on [redacted]
The program began reviewing med error process on the daily stand up utilizing the checklist on [redacted] The checklist is reviewed with the on-call to ensure none of the steps were missed. The checklists are sent to the team after completion and saved in the file.
All med errors are reviewed by the entire team on Stand Up daily, again during the monthly safety meeting on the 3rd Friday of every month as well as weekly during high risk. The review of the checklist is done by the entire team to ensure completion of requirements. The Quality Improvement Specialist completes an annual analysis of all med errors in October of each year. The team also meets the Executive team every other Wednesday to review med errors.

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

Implemented [redacted] 07/08/2024)