Certificate of Compliance

This certificate is hereby granted to **MILLCREEK MANOR**
LEGAL ENTITY

To operate **LECOM PARKSIDE AT GLENWOOD**
NAME OF FACILITY OR AGENCY

Located at **41 WEST GORE ROAD, ERIE, PA 16509**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

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 **144**
(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 16**

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 **December 3, 2024** until **June 3, 2025**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **453841**

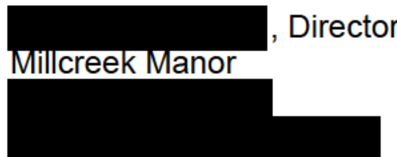
ISSUING OFFICER

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

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 3, 2024



, Director
Millcreek Manor

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

Dear :

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspection on May 14, 2024 and September 25, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 45384) dated January 29, 2024 to January 29, 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) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from December 3, 2024 to June 3, 2025.

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

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.

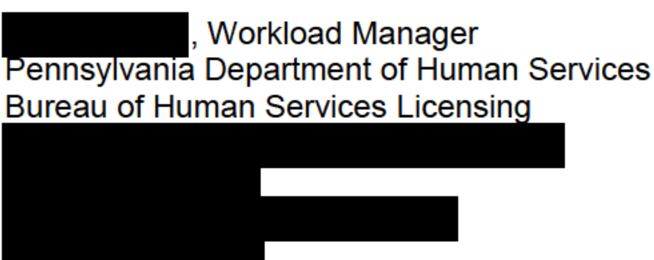
55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	X Fine Per resident Per day	= Calculated Fine Per day	Mandated Correction Date (to avoid Fine)
42(b)	II	53	$5	$265	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the 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.

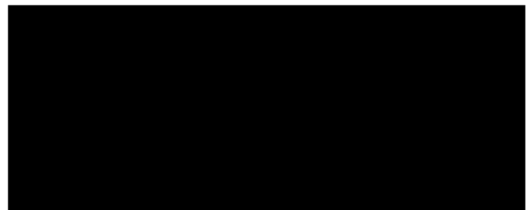
No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain 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], Workload Manager
Pennsylvania Department of Human Services
Bureau of Human Services Licensing

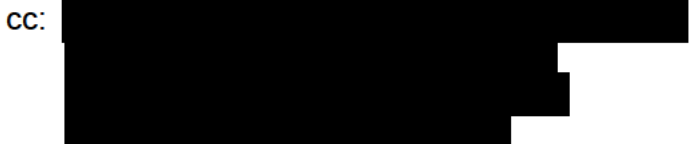


This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.



Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: 

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

Facility Information

Name: *LECOM PARKSIDE AT GLENWOOD* **License #**: *45384* **License Expiration**: *01/29/2025*

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

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

Administrator

Legal Entity

Name: *MILLCREEK MANOR*

Address:

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *78* **Waking Staff**: *59*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *05/14/2024*

Inspection Dates and Department Representative

05/14/2024 On Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd Floor* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *15* **Are 60 Years of Age or Older**: *53*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *4*

Have Mobility Need: *25* **Have Physical Disability**: *1*

Inspections / Reviews

05/14/2024 - Partial

Lead Inspector: **Follow Up Type**: *POC Submission* **Follow Up Date**: *06/15/2024*

Inspections / Reviews *(continued)*

06/28/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *08/12/2024*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *07/05/2024*

07/12/2024 POC Submission

Submitted By: [redacted]
Date Submitted: *08/12/2024*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *08/06/2024*

11/07/2024 Document Submission

Submitted By: [redacted]
Date Submitted: *08/12/2024*
Reviewer: [redacted]
Follow Up Type: *Enforcement*

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 #1 resides in the and is diagnosed with . resident assessment and support plan (RASP), dated , indicates needs moderate supervision, exhibits exit seeking behaviors, wears a wanderguard for her safety, and does not know where is.

Resident #2 resides in the and is diagnosed with unspecified RASP, dated indicates needs moderate supervision, and has moderate problems with orientation to time, place and person.

On there were 16 residents requiring supervision in the SDCU. Staff interviews indicate two direct care staff are regularly scheduled to work in the SDCU. However, on there was only 1 direct care staff person working in the SDCU.

On at approximately staff person A, the only staff person working in the SDCU, found resident #1 and resident #2 together in resident #2's bedroom. Staff person A attempted to redirect resident #1 to leave the bedroom. Staff person A left resident #2's bedroom, later returned, and found the bedroom door locked from the inside. Staff person A called staff person B and requested assistance. Staff person B arrived and tried opening resident #2's bedroom door; however, it was still locked. Staff person B knocked on the door before opening it with key and both residents were heard saying, "keep the door closed". Staff person B opened the door and observed resident #1 and resident #2 naked on the bed performing oral sex on each other. Staff person B asked the residents to put their clothes on and escorted resident #1 to bedroom.

Repeat Violation: 8/3/2023 et al.

Plan of Correction ***Accept - 07/12/2024)***

Effective May 15th, 2024, there have been 2 staff members assigned to the memory care area. Resident #1 and Resident#2 have been supervised an no further events have occurred. DON or designee are having Resident #1 and Resident #2 assessed by as soon as possible based on schedule. To determine if they have the capacity to consent to sexual activity. (Soonest is October 2024)
All facility staff have been assigned dementia training in Collins learning and will have a presentation on sexuality in dementia care at staff meeting on July 11th. This training was submitted by s, SW who is a dementia trainer. All staff assigned Collins dementia training will have it completed by July 30th, 2024 DON or designee are reviewing staffing patterns daily.

Licensee's Proposed Overall Completion Date: *07/30/2024*

Not Implemented 11/07/2024)

60a Staff/Support Plan

2. 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

Resident #1 resides in the secure dementia care unit (SDCU) and is diagnosed with Alzheimer's disease. Her resident

60a - Staff/Support Plan (continued)

assessment and support plan (RASP), dated [redacted] indicates she needs moderate supervision, exhibits exit seeking behaviors, wears a wanderguard for [redacted] safety, and [redacted] does not know where [redacted] is.

Resident #2 resides in the SDCU and is diagnosed with unspecified [redacted] His RASP, dated [redacted], indicates [redacted] needs moderate supervision, and has moderate problems with orientation to time, place and person.

On 5/9/24, there were 16 residents requiring supervision in the SDCU. Staff interviews indicate two direct care staff are regularly scheduled to work in the SDCU. However, on 5/9/24 from 2:00 p.m. to 4:30 p.m., there was only 1 direct care staff person working in the SDCU.

On [redacted] at approximately [redacted] staff person A, the only staff person working in the SDCU, found resident #1 and resident #2 together in resident #2's bedroom. Staff person A attempted to redirect resident #1 to leave the bedroom. Staff person A left resident #2's bedroom, later returned, and found the bedroom door locked from the inside. Staff person A called staff person B and requested assistance. Staff person B arrived and tried opening resident #2's bedroom door; however, it was still locked. Staff person B knocked on the door before opening it with [redacted] key and both residents were heard saying, "keep the door closed". Staff person B opened the door and observed resident #1 and resident #2 naked on the bed performing oral sex on each other. Staff person B asked the residents to put their clothes on and escorted resident #1 to [redacted] bedroom.

Plan of Correction ***Directed [redacted] - 07/12/2024)***

On 5/9/24 the census in the building was 54 with 25 immobile residents (including 16 in SDCU) the total number of waking hours of care provided were 87, which is over minimum requirements. DON or designee will ensure that staffing hours meet regulatory requirements daily. Since 5/15/24 the DON or designee will review staffing patterns daily to ensure facility staff are available to meet the needs of residents as specified in the resident's assessment and support plan, including adjusting staff assignments as needed.

Proposed Overall Completion Date: 07/30/2024

Directed:

Per the administrator, effective May 15th, 2024, there have been 2 staff members assigned to the memory care area.
[redacted] 7/12/24

Directed Completion Date: *07/30/2024*

Not Implemented [redacted] - 11/07/2024)

187b - Date/Time of Medication Admin.

3. 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

On [redacted] resident #3 was prescribed [redacted], take 1 tablet by mouth in the evening for [redacted] for 2 weeks. At the end of the 2-week timeframe, resident #3 still had 11 tablets remaining. Resident #3 was not administered 11 doses of this medication between [redacted]; however, resident #3's [redacted] medication administration record (MAR) indicates the medication was administered every day from [redacted]

187b - Date/Time of Medication Admin. *(continued)*

Plan of Correction ***Directed - 07/12/2024)***

CMT that made the medication error was educated along with other staff on proper dispensing of medications on 4/11/24 and again on 5/17/24 by , DON. CMT was also assigned additional training on Collins learning. Processes reviewed included dispensing and documenting medications given. If a medication is not given it will be documented on the MAR as to the reason why and physician and family will be notified. DON or designee will audit MARS to maintain compliance with regulations. Audits of MARS and medications will be conducted by DON or designee weekly.

Proposed Overall Completion Date: 07/30/2024

Directed:
By 7/30/24, the CMT that made the medication error will complete additional training on Collins learning as listed above. Documentation will be kept.
7/12/24

Directed:
Beginning 7/30/24 and weekly thereafter, the administrator or designee will conduct audits as listed above. Documentation will be kept.
7/12/24

Directed Completion Date: *07/30/2024*

Implemented (- 11/07/2024)

187d - Follow Prescriber's Orders

4. Requirements

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

Description of Violation

On resident #3 was prescribed , take 1 tablet by mouth in the evening for agitation for 2 weeks. At the end of the 2-week timeframe, resident #3 still had 11 tablets remaining. Resident #3 was not administered 11 doses of this medication between ; however, resident #3's MAR indicates the medication was administered every day from

Plan of Correction ***Directed 07/12/2024)***

CMT that made the medication error was educated along with other staff on proper dispensing of medications on 4/11/24 and again on 5/17/24 by DON. CMT was also assigned additional training on Collins learning which is ongoing. Processes reviewed included dispensing and documenting medications given. If a medication is not given it will be documented on the MAR as to the reason why and physician and family will be notified. DON or designee will audit MARS to maintain compliance with regulations monthly beginning July 1, 2024, Administrator and DON will present education on 5 rights of medication on July 11th, 2024, and ongoing.

Proposed Overall Completion Date: 07/11/2024

Directed:

187d Follow Prescriber's Orders (continued)

By 7/30/24, the CMT that made the medication error will complete additional training on Collins learning as listed above. Documentation will be kept.

7/12/24

Directed Completion Date: *07/30/2024*

Implemented (- 11/07/2024)

228h - Grounds Discharge/Transfer

5. Requirements

2600.

228.h. The only grounds for discharge or transfer of a resident from a home are for the following conditions:

1. If a resident is a danger to himself or others.
2. If the legal entity chooses to voluntarily close the home, or a portion of the home.
3. If a home determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the home. If a resident or the resident's designated person disagrees with the home's decision to discharge or transfer, consultation with an appropriate assessment agency or the resident's physician shall be made to determine if the resident needs a higher level of care. A plan for other placement shall be made as soon as possible by the administrator in conjunction with the resident and the resident's designated person, if any. If assistance with relocation is needed, the administrator shall contact appropriate local agencies, such as the area agency on aging, county mental health/intellectual disability program or drug and alcohol program, for assistance. The administrator shall also contact the Department's personal care home regional office.
4. If meeting the resident's needs would require a fundamental alteration in the home's program or building site, or would create an undue financial or programmatic burden on the home.
5. If the resident has failed to pay after reasonable documented efforts by the home to obtain payment.
6. If closure of the home is initiated by the Department.
7. Documented, repeated violation of the home rules.

Description of Violation

On , the home issued a 30 day notice to resident #3. The 30 day notice issued was not for any of the permitted conditions.

Plan of Correction ***Accept - 07/12/2024)***

All residents and resident families were mailed a letter including the amended area on 7/8/24. Each resident currently has residing in the community was given a copy of the new handbook the week of July 8th. Beginning July 8th Administrator or designee will check each handbook prior to distributing them to new residents to ensure they are aware of the eviction criteria.

Proposed Overall Completion Date: 07/30/2024

Licensee's Proposed Overall Completion Date: *07/30/2024*

Implemented - 11/07/2024)

231b - Medical Evaluation

6. Requirements

2600.

231b - Medical Evaluation *(continued)*

231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

Description of Violation

Resident #1 was admitted to the SDCU on [redacted]; however, the resident's medical evaluation indicating the need for the resident to be served in an SDCU was not completed until [redacted]

Plan of Correction ***Directed ([redacted] - 07/12/2024)***

The resident was admitted to SDCU on [redacted] due to [redacted]. Resident was diagnosed and treated for a [redacted] that may have contributed to [redacted]. When it was determined by medical staff that [redacted] were continuing a new DME was completed on the physician's next visit to the facility. Administrator or designee will monitor SDCU admissions to ensure all paperwork needed in the SDCU will be completed within 72 hours after admission. Administrator or designee will audit each admission to the SDCU to ensure the medical evaluation is completed in 72 hours on 7/4/24 and ongoing.

Proposed Overall Completion Date: 07/04/2024

Directed:
Beginning 7/4/24 and monthly thereafter, the administrator or designee will conduct audits as listed above. Documentation will be kept.
SQ 7/12/24

Directed Completion Date: *07/04/2024*

Implemented ([redacted] - 11/07/2024)

231c - Preadmission Screening

7. 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 #1 was admitted to the SDCU on [redacted]. However, the resident does not have a written cognitive preadmission screening.

Resident #2 was admitted to the SDCU on [redacted]. However, the resident does not have a written cognitive preadmission screening.

Plan of Correction ***Directed ([redacted] - 07/12/2024)***

The administrator or designee performs a cognitive assessment on all admissions prior to admission to the facility beginning July 4th, 2024. The administrator or designee will perform an audit of all charts to ensure these assessments are completed for each resident by July 11th. These processes will be ongoing. Please see the attached documents for resident #1 and resident #2

231c - Preadmission Screening (continued)

Proposed Overall Completion Date: 07/11/2024

Directed:
By 7/30/24 and monthly thereafter, the administrator or designee will audit all SDCU resident files to ensure 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 is completed for each resident within 72 hours prior to admission to the SDCU. Documentation shall be kept.
SQ 7/12/24

Directed Completion Date: *07/30/2024*

Implemented (- 11/07/2024)

Facility Information

Name: *LECOM PARKSIDE AT GLENWOOD* **License #**: *45384* **License Expiration**: *01/29/2025*

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

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *MILLCREEK MANOR*

Address:

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *73* **Waking Staff**: *55*

Inspection Information

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

Reason: *Incident, Monitoring* **Exit Conference Date**: *09/25/2024*

Inspection Dates and Department Representative

09/25/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *53*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd Floor* **Capacity**: *16* **Residents Served**: *14*

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *53*

Diagnosed with Mental Illness: *9* **Diagnosed with Intellectual Disability**: *4*

Have Mobility Need: *20* **Have Physical Disability**: *1*

Inspections / Reviews

09/25/2024 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/21/2024*

10/30/2024 - POC Submission

Submitted By: **Date Submitted**: *10/31/2024*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *11/01/2024*

Inspections / Reviews *(continued)*

11/07/2024 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/31/2024*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date:** *12/01/2024*

184a - Resident's Meds Labeled

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is prescribed every 6 hours for However, the resident's medication label indicates) by mouth/sublingually every 2 hours as needed for

Resident #1 is prescribed every 12 hours for . However, the resident's medication label indicates by mouth/sublingually every 2 hours as needed for .

Repeat Violation: 11/14/23, 9/7/23

Plan of Correction ***Accept 10/30/2024)***

CMT that assisted the inspector called pharmacy immediately after discovering these errors. Pharmacy corrected label and it was changed prior to inspectors leaving the facility. DON, ADON or designee continue to weekly audits of all med carts on Wednesdays. Any errors are reported to pharmacy immediately.

Licensee's Proposed Overall Completion Date: *10/22/2024* ***Implemented - 11/07/2024)***

Violation Withdrawn
/21/24