



CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: January 10, 2025

[REDACTED], Program Director
Mentor ABI LLC
6816 West Lake Road
Fairview, Pennsylvania 16415

RE: Neurorestorative Pennsylvania
License/COC #: 44663

Dear [REDACTED]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on June 27, 2024, November 13, 2024, December 9, 2024, and December 11, 2024, of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

As a result of violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REFUSES to RENEW your FIRST PROVISIONAL certificate of compliance (license number 44663) to operate the above facility. The Department's decision to refuse to renew your license is based on the violations attached to this notice and your failure to comply with the Department's regulations, gross incompetence, negligence and misconduct in operating the facility, and failure to submit an acceptable plan to correct noncompliance items, and 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).

In accordance with 55 Pa. Code § 2600.269 (b) (relating to ban on admissions) no new resident admissions are permitted after the date of this letter.

If you disagree with the decision to REFUSE TO RENEW your 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. Your appeal must indicate the reasons for the appeal, and you must be as specific as possible regarding your areas of disagreement with the Department's decision.

If you decide to appeal, 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

[REDACTED]

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.

The enclosed violation report specifies plans of correction and dates by which corrections must be made. If you choose to appeal, an acceptable plan of correction must be followed during your operation pending your appeal. Neurorestorative Pennsylvania is required to remain in full compliance with all applicable statutes and regulations, including but not limited to Article X of the Human Services Code, 62 P.S. §§ 1001 et seq., and 55 Pa. Code Ch. 2600 (relating to Personal Care Homes)

Sincerely,

[REDACTED]

Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [REDACTED], Office of General Counsel
[REDACTED], Bureau Director
[REDACTED], Director of Operations
[REDACTED], Regional Director

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

Facility Information

Name: *NEURORESTORATIVE PENNSYLVANIA* License #: *44663* License Expiration: *09/26/2024*
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: *6816 WEST LAKE ROAD, FAIRVIEW, PA, 16415*
Phone: [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *01/26/2015* Issued By: *Fairview Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
Reason: *Renewal* Exit Conference Date: *06/27/2024*

Inspection Dates and Department Representative

06/27/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

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

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *7* Are 60 Years of Age or Older: *2*
Diagnosed with Mental Illness: *8* Diagnosed with Intellectual Disability: *1*
Have Mobility Need: *7* Have Physical Disability: *7*

Inspections / Reviews

06/27/2024 Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *07/28/2024*

09/04/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/11/2024

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 09/09/2024

09/30/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 09/18/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission

Follow Up Date: 10/21/2024

01/06/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 11/04/2024

[REDACTED] [REDACTED]

Follow Up Type: Enforcement

64c Annual Training

1. Requirements

2600.

64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person B, [REDACTED], only completed 7 of the required 24 hours of Department-approved training in training year 2023.

Plan of Correction

Accept [REDACTED] - 09/30/2024)

Staff person B completed the required training but had only logged it; [REDACTED] was not aware that [REDACTED] needed to keep [REDACTED] certificates.

On 8.10.24 HR was notified of the requirement for all certificates to be submitted each year with the log of trainings to ensure compliance. At this time all Administrators were notified of the requirement as well.

Staff person B will make up the 14 hours of training from 2023 by December 2024.

Additionally, tracking was added to the programs Equality Grid to be reviewed during the Safety Committee meeting each month. Hours will not be tracked until the appropriate certification has been submitted to the employee file.

Administrators will submit all 2024 hours by 8.31.24 and track them on the EQG. This will be reviewed during the monthly Safety Meeting and will be noted on the monthly notes. Review during the Safety Meeting will begin in September reviewing the current year and each month there after.

Licensee's Proposed Overall Completion Date: 12/31/2024

Implemented [REDACTED] - 12/24/2024)

65f Training Topics

2. Requirements

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 6. Safe management techniques.

Description of Violation

Direct care staff person A did not receive training in safe management techniques in training year 2023.

Plan of Correction

Accept [REDACTED] - 09/19/2024)

See attached.

The program is requesting this be withdrawn. Staff person A had this training in June of 2023. See paged 28 of the attached document.

The Office Administrator will receive training by the QIS by 9/30.24 on the organization of staff files. Documentation of education will be kept on file.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented [REDACTED] - 12/24/2024)

65g Annual Training Content

3. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

Staff person A did not receive training in emergency preparedness procedures in training year 2023.

Plan of Correction

Accept () - 09/19/2024)

The program is requesting this be withdrawn. See attached verification of training.

The Office Administrator will receive training by the QIS by 9/30.24 on the organization of staff files. Documentation of education will be kept on file.

Licensee's Proposed Overall Completion Date: 09/30/2024

Implemented () - 12/24/2024)

92 Windows

4. 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

At 11:11 AM the Laundry Room screen was torn all the way across the bottom.

At 11:22 AM Bedroom #4 is missing a screen in the right window.

Plan of Correction

Accept () - 09/04/2024)

By 7/5/24 the program replaced the screen in the Laundry Room and the right screen in Bedroom #4 was replaced by (), maintenance.

On 8/10/24 the programs monthly Environmental Survey was updated by (). It was sent to the programs Team Lead to begin being utilized during the month of August. This will be submitted to QI once completed.

On 8/12/24 Maintenance will order extra screens to have available at all times. In the event a screen is broken it can be completed immediately.

All staff were assigned education in Relias on the Regulation by () on (). It is due to be completed by 8.31.24.

Licensee's Proposed Overall Completion Date: 08/31/2024

Implemented () - 12/24/2024)

101j7 Lighting/Operable Lamp

6. 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

At 11:21 AM bedroom #3 does not have a source of light that can be turned on/off from bedside. Repeat Violation 7/26/23

Plan of Correction

Accept () - 09/04/2024)

The bedside lamp was replaced by () or ().

On May 2, 2024 a task was added to POC for staff to ensure the bed side light is available, working and in good

101j7 Lighting/Operable Lamp (continued)

repair; it was noted that this was not being completed. On 8.10.24 a Record of Discussion was completed by [REDACTED] with all the information related to the education that was provided and the requirement to complete documentation. RS, [REDACTED], will review the ROD with all staff members not completing assigned tasks and appropriate documentation by 8.31.24.

Licensee's Proposed Overall Completion Date: 08/31/2024

Not Implemented [REDACTED] - 12/24/2024)

103f - Refrigerator/Freezer Temps

7. Requirements

2600.

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

Description of Violation

On 6/27/24 at 10:51 AM the temperature in the refrigerator was 46 degrees Fahrenheit and at 1:21 PM it was 46 degrees Fahrenheit.

Plan of Correction

Accept [REDACTED] - 09/30/2024)

The Fridge was reviewed by maintenance on 6/28/24 and fixed; no further concerns were noted with the temperature.

Education will be completed with the staff by [REDACTED] by 8/31/24.

103f Refrigerator / Freezer Temps

Food requiring refrigeration shall be stored at or below 40 degrees F. Each home has a posted temperature log. The staff should check the thermometer for the temperature and document it on the log. Any temps noted to be over 40 degrees should be noted on the log and a maintenance request should be done. Additionally, staff should notify their supervisor and document the concern in the shift report.

Staff temperature checks and documentation in the temperature log will be completed at least once daily

Proposed Overall Completion Date: 09/30/2024

Licensee's Proposed Overall Completion Date: 09/30/2024

Not Implemented [REDACTED] - 12/24/2024)

107c - Food/Water 3 Day Supply

8. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

107c - Food/Water 3 Day Supply (continued)

Description of Violation

On 6/27/24, the home served 8 residents, requiring 24 gallons of emergency drinking water. However, the home had only 10 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction

Accept (█) - 09/30/2024)

The program is requesting this violation be withdrawn. The home had an additional 10 regular sized gallons of water available, however, the program also utilizes Cold Rock and has a water system in the home. The home always has 6 additional Cold Rock 5 gallon jugs available (30 gallons). These are stored in the homes storage room and were available and on site at the time of the inspection.

Education will be provided to the RS and TL on the requirements of Emergency water supplies. Emergency supplies should be available to the inspector at the time of inspection. Education will be completed by █ by 9.30.24. Documentation of education will be kept on file.

Licensee's Proposed Overall Completion Date: 09/30/2024

Not Implemented (█) - 12/24/2024)

171b5 - First Aid Kit

9. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

At 3:30 PM the First Aid Kit in the Transit Van did not contain scissors.

Plan of Correction

Accept (█) - 09/04/2024)

The scissors were replaced on 6/27/24 by █.

Education will be provided to the Transportation Team by 8/31/24 by Katy Peterson regarding how to complete the checklists and the importance of reviewing all items on the checklist.

Beginning in August all Vehicle Checklists will be submitted to the Residential Supervisor to review; the review will begin in September of the August checklist. The RS will review the checklist each month to ensure compliance. The review will be documented on the vehicle checklists and submitted to QI to be kept on file.

Licensee's Proposed Overall Completion Date: 09/27/2024

Not Implemented (█) - 12/24/2024)

Facility Information

Name: *NEURORESTORATIVE PENNSYLVANIA* License #: *44663* License Expiration: *09/26/2024*
 Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA 16415*
 County: *ERIE* Region: *WESTERN*

Administrator

[Redacted]

Legal Entity

Name: *MENTOR ABI LLC*
 Address: *6816 WEST LAKE ROAD, FAIRVIEW, PA, 16415*
 [Redacted]

Certificate(s) of Occupancy

Type: *I-1* Date: *01/26/2015* Issued By: *Fairview Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident, Interim* Exit Conference Date: *11/19/2024*

Inspection Dates and Department Representative

11/13/2024 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *8* Residents Served: *8*
 Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
 Hospice
 Current Residents: *0*
 Number of Residents Who:
 Receive Supplemental Security Income: *6* Are 60 Years of Age or Older: *2*
 Diagnosed with Mental Illness: *8* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *7* Have Physical Disability: *7*

Inspections / Reviews

11/13/2024 - Partial
 Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *12/19/2024*

Inspections / Reviews (*continued*)

12/24/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/19/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/31/2025

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 [REDACTED], an allegation of abuse for residents #1, #2, #3, #4, and #5 by staff was reported to the administrator. The home did not report these incidents to the Department until [REDACTED].

Repeat Violation: 3/21/24, 2/15/24 et al

Plan of Correction

Directed ([REDACTED] - 12/24/2024)

On 12/10/24 the program assigned all staff the video training, in Relias, Abuse: Preventing, Recognizing and Reporting Abuse. This training will be completed by 1/10/2025.

To ensure compliance with this regulation the Admin Team will complete the online Mandated Reporter Training. They will be required to complete this training by 1/10/2025. Verification of completion will be submitted to the PD and kept on file.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

The administrator or designee will ensure all staff complete Relias, Abuse: Preventing, Recognizing and Reporting Abuse, and the administration team will complete the online Mandated Reporter Training by 1/10/25.

Documentation will be kept.

[REDACTED] 12/24/24

Directed:

By 1/31/25, all staff will be trained by a Department approved outside source on reporting requirements.

Documentation will be kept.

[REDACTED] 12/24/24

Directed Completion Date: 01/31/2025

42b - Abuse

2. 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

On [REDACTED] at approximately [REDACTED], Staff person A placed medications on the kitchen counter for staff person B to mix into the residents' drinks as prescribed including the following:

[REDACTED]

Staff interviews indicate staff person B then put the medications into a blue glove and threw the medications into the trash stating, "Oh no, we're not doing this shit today". Interviews also indicate that staff person B stated he/she did this because these meds make the residents defecate which the staff will have to clean up. On [REDACTED], staff found the discarded medication in the garbage.

Repeat Violation: 3/15/24, 2/15/24 et al

Plan of Correction

Directed ([REDACTED] - 12/24/2024)

Staff members A and B were suspended by the homes supervisor of [REDACTED] pending investigation. Staff members A and B were terminated on [REDACTED] by the Program Director.

On On 12/10/24 the program assigned all staff the video training, in Relias, Abuse: Preventing, Recognizing and Reporting Abuse. This training will be completed by 1/10/2025.

To ensure compliance with this regulation the Admin Team will complete the online Mandated Reporter Training. They will be required to complete this training by 1/10/2025. Verification of completion will be submitted to the PD and kept on file.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

The administrator or designee will ensure the administration team will complete the online Mandated Reporter Training by 1/31/25. Documentation of training will be kept.

[REDACTED] 12/24/24

Directed:

By 1/31/25, weekly for 1 month, and monthly thereafter, the administrator or staff person qualified to administer medication will observe each staff person qualified to administer medication conduct a medication pass.

42b - Abuse (continued)

Documentation will be kept.

█ 12/24/24

Directed Completion Date: 01/31/2025

101j7 - Lighting/Operable Lamp

3. 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

Bedroom #3's bedside light was out of reach from the bed and not plugged in.

Repeat Violation: 7/26/23

Plan of Correction

Directed █ - 12/24/2024)

By 12/20/24 the program Supervisor will complete a walk through of the program to ensure all participants have an operable lamp or other source of lighting that can be turned on at bedside. Any source found to be inoperable will be replaced immediately.

All staff will be provided education on the regulation and its requirements. They will also be provided education on completing a check of the Bedside Lamp and the requirement for documenting the check on the POC tasks. This education will be completed by the Supervisor or designee by 1/10/2025.

By 12/20/24 the program will update the Weekly Walk Through checklist that is to be completed by the Supervisor and/or Administrator weekly. The checklist update will include verifying each participant has an operable bedside light. The checklist will be submitted to be kept on file. The new checklist will begin the week of 12/23/24.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

By 1/31/25 and daily thereafter, the administrator or designated staff person will 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.

Documentation will be kept.

█ 12/24/24

Directed Completion Date: 01/31/2025

103f - Refrigerator/Freezer Temps

4. Requirements

103f - Refrigerator/Freezer Temps (continued)

2600.

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

Description of Violation

At 12:16 p.m., there was no thermometer in the freezer.

Plan of Correction

Directed (█) - 12/24/2024

By 12/20/24 the program Supervisor will complete a walk through of the program to ensure all Refrigerators/Freezers have a thermometer in them and will check the current temperature. Any issues will be reviewed with the maintenance team to ensure appropriate correction.

All staff will be provided education on the regulation and its requirements. They will also be provided education on completing a daily Temperature check and the necessary documentation. This education will be completed by the Supervisor or designee by 1/10/2025.

On 12/12/24 the program updated the Weekly Walk Through checklist that is to be completed by the Supervisor and/or Administrator weekly. The update includes instructions on how to complete the walk through and verify temps. The checklist will be submitted to be kept on file. The new checklist began the week of 12/16/24.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

By 1/31/25 and daily thereafter, the administrator or designee will inspect all refrigerators and freezers to ensure thermometers are present, and food requiring refrigeration is stored at or below 40°Fahrenheit and frozen food is stored at or below 0°Fahrenheit. Documentation will be kept.

█ 12/24/24

Directed Completion Date: 01/31/2025

107c - Food/Water 3 Day Supply

5. Requirements

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

Description of Violation

On 11/13/24, the home served 8 residents, requiring 24 gallons of emergency drinking water. However, the home had only 15 gallons. The home does not have a contract with a local bottled water supplier.

Plan of Correction

Accept (█) - 12/24/2024

By 12/20/24 the program Supervisor will complete a walk through of the program to ensure the program has 24 gallons of emergency drinking water available. If it is identified that it does not, the program will purchase additional water immediately.

By 12/31/24 the Supervisor and/or Administrator will update the monthly Environmental Survey to include checking the homes emergency water supply. The form will include the individual homes water requirements and staff will need to indicate the amount in the home at that time. The Team Leads will be educated by the Supervisor by 12/31/24 on the new requirements. The new Environmental Surveys will be started during the month of January 2025.

107c - Food/Water 3 Day Supply (continued)

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/31/2025

Licensee's Proposed Overall Completion Date: 01/31/2025

171b5 - First Aid Kit**6. Requirements**

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the van used to transport residents does not include scissors and tweezers.

Plan of Correction

Directed (█) - 12/24/2024

By 12/20/24 the program Supervisor will complete a First Aid Kit Checklist in the home and the vehicle. Any missing items will be replaced immediately. Documentation of the review will be kept on file.

All staff will be educated on the First Aid Checklist requirements by 1/10/2025.

On 12/12/24 the program updated the Weekly Walk Through checklist that is to be completed by the Supervisor and/or Administrator weekly. The update includes instructions on how to complete the walk through and the First Aid Kit requirements. The new checklist began the week of 12/16/24.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

By 1/31/25, the administrator will educate all staff regarding the First Aid Checklist requirements. Documentation will be kept.

█ 12/24/24

Directed Completion Date: 01/31/2025

182c - Medication Administration**7. Requirements**

2600.

182.c. Medication administration includes the following activities, based on the needs of the resident:

1. Identify the correct resident.
2. If indicated by the prescriber's orders, measure vital signs and administer medications accordingly.
3. Remove the medication from the original container.
4. Crush or split the medication as ordered by the prescriber.
5. Place the medication in a medication cup or other appropriate container, or in the resident's hand.

182c - Medication Administration (continued)

- 6. Place the medication in the resident's hand, mouth or other route as ordered by the prescriber, in accordance with the limitations specified in subsection (b)(4).
- 7. Complete documentation in accordance with § 2600.187 (relating to medication records).

Description of Violation

On [REDACTED] at approximately 8:00 AM, Staff person A placed medications on the kitchen counter for staff person B to mix into the residents' drinks as prescribed including the following:

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Staff interviews indicate staff person B then put the medications into a blue glove and threw the medications into the trash stating, "Oh no, we're not doing this shit today". Interviews also indicate that staff person B stated he/she did this because these meds make the residents defecate which the staff will have to clean up. On 11/6/24, staff found the discarded medication in the garbage.

Repeat Violation: 2/15/24 et al

Plan of Correction

Directed [REDACTED] - 12/24/2024)

Staff members A and B were suspended by the homes supervisor [REDACTED] pending investigation. Staff members A and B were terminated on [REDACTED] by the Program Director.

All staff will be provided education on Policy 1.53b Medication Administration and the Med Error Procedure to include disciplinary action. All staff will be provided this education by the Supervisor or designee by 1/10/2025.

On 12/12/24 the program updated the Weekly Walk Through checklist that is to be completed by the Supervisor and/or Administrator weekly. The update includes completing a Medication Pass Observation or Pass Verification dependent on the time the checklist is completed. The update includes instructions on how to complete this and document it. The new checklist began the week of 12/16/23.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Directed:

By 1/31/25, weekly for 1 month, and monthly thereafter, the administrator or staff person qualified to administer medication will observe each staff person qualified to administer medication conduct a medication pass.

Documentation will be kept.

[REDACTED] 12/24/24

182c - Medication Administration (continued)

Directed Completion Date: 01/31/2025

187d - Follow Prescriber's Orders

8. Requirements

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

Description of Violation

On [REDACTED] at approximately 8:00 AM, Staff person A placed medications on the kitchen counter for staff person B to mix into the residents' drinks as prescribed including the following:

[REDACTED]

Staff interviews indicate staff person B then put the medications into a blue glove and threw the medications into the trash stating, "Oh no, we're not doing this shit today". Interviews also indicate that staff person B stated he/she did this because these meds make the residents defecate which the staff will have to clean up. On [REDACTED], staff found the discarded medication in the garbage.

Repeat Violation: 2/15/24 et al

Plan of Correction

Directed ([REDACTED] - 12/24/2024)

Staff members A and B were suspended by the homes supervisor of [REDACTED] pending investigation. Staff members A and B were terminated on [REDACTED] by the Program Director.

All staff will be provided education on Policy 1.53b Medication Administration and the Med Error Procedure to include disciplinary action. All staff will be provided this education by the Supervisor or designee by 1/10/2025. On 12/12/24 the program updated the Weekly Walk Through checklist that is to be completed by the Supervisor and/or Administrator weekly. The update includes completing a Medication Pass Observation or Pass Verification dependent on the time the checklist is completed. The update includes instructions on how to complete this and document it. The new checklist began the week of 12/16/23.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/10/2025

Facility Information

Name: *NEURORESTORATIVE PENNSYLVANIA* License #: *44663* License Expiration: *09/26/2024*
 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: *6816 WEST LAKE ROAD, FAIRVIEW, PA, 16415*
 [REDACTED]

Certificate(s) of Occupancy

Type: *I-1* Date: *01/26/2015* Issued By: *Fairview Township*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *15* Waking Staff: *11*

Inspection Information

Type: *Partial* Notice: *Unannounced* BHA Docket #:
 Reason: *Complaint, Incident* Exit Conference Date: *12/11/2024*

Inspection Dates and Department Representative

12/09/2024 - On-Site: [REDACTED]
 12/11/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *8* Residents Served: *8*
 Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:
 Hospice
 Current Residents: *0*
 Number of Residents Who:
 Receive Supplemental Security Income: *6* Are 60 Years of Age or Older: *1*
 Diagnosed with Mental Illness: *8* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *7* Have Physical Disability: *7*

Inspections / Reviews

12/09/2024 - Partial
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *12/24/2024*

Inspections / Reviews (*continued*)

12/24/2024 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/24/2024

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 01/31/2025

23a - Activities of Daily Living Assistance

1. Requirements

2600.

23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident #1's assessment, dated [REDACTED], indicates the resident requires total physical assistance with bladder management. The resident's support plan, dated [REDACTED] indicates direct care staff will meet this need by providing total physical assistance with incontinent care before and after breakfast, lunch, dinner, right before bed, right after getting up from bed, and hourly outside of these events. Resident #1 did not receive this assistance as required. On [REDACTED], resident #1 was provided incontinence care at [REDACTED], as documented on his briefs. On [REDACTED] at approximately [REDACTED], staff person A found resident #1 lying in his bed, soaked in urine, and still wearing the same brief dated [REDACTED].

Repeat Violation: 4/9/24, 8/31/23

Plan of Correction

Directed ([REDACTED] - 12/24/2024)

On 12/10/24 the program assigned all staff the video training, in Relias, Abuse: Preventing, Recognizing and Reporting Abuse. This training will be completed by 1/10/2025.

To ensure compliance with this regulation the Admin Team will complete the online Mandated Reporter Training. They will be required to complete this training by 1/10/2025. Verification of completion will be submitted to the PD and kept on file.

All staff that work in the home will receive in-person training by the Administrator and/or Supervisor on all participants Support plans; this training is to be completed by 1/15/24.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance.

Proposed Overall Completion Date: 01/15/2025

Directed:

By 1/31/25 and monthly thereafter, the administrator will meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the resident's RASP, to ensure all resident's needs are met. The administrator will meet with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs. Documentation will be kept.

[REDACTED] 12/24/24

Directed Completion Date: 01/31/2025

63a - First Aid/CPR Training

2. Requirements

2600.

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

Staff person B, the home's Quality Improvement Specialist, Licensed Practical Nurse, Certified Brain Injury Specialist, Personal Care Home Administrator, and an American Red Cross First Aid/CPR/AED Instructor, provided

63a - First Aid/CPR Training (continued)

First Aid/CPR training certifications to multiple staff who did not adequately complete the hands-on practice portion of the training, to include staff person C and staff person D.

On [REDACTED], 8 residents were present in the home. During this time there were 5 staff persons present in the home; however, none of the staff persons were trained in first aid and certified in obstructed airway techniques and CPR.

On [REDACTED], 8 residents were present in the home. During this time there were 2 staff persons present in the home; however, none of the staff persons were trained in first aid and certified in obstructed airway techniques and CPR.

Plan of Correction

Directed [REDACTED] - 12/24/2024)

The program brought in outside CPR trainers 12/14/24 - 12/20/24.

At this time all programs have at least one CPR/FA Certified staff member on each shift.

The program will work with an outside entity to ensure training compliance following hire and bi-annually as required.

HR runs monthly Certification reports that are sent to the program; these will be reviewed and monitored monthly by the Supervisors and Program Director to ensure compliance.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance

Proposed Overall Completion Date: 12/24/2024

Directed:

By 1/31/25 and daily thereafter, the administrator or designee will review the staff schedule to ensure at least 1 staff person who is trained in first aid and certified in obstructed airway techniques and CPR, who did not receive this certification from [REDACTED] is present in the home at all times. Documentation will be kept.

[REDACTED] 12/24/24

Directed Completion Date: 01/31/2025

63b - Current First Aid Training

3. Requirements

2600.

63.b. Current training in first aid and certification in obstructed airway techniques and CPR shall be provided by an individual certified as a trainer by a hospital or other recognized health care organization.

Description of Violation

Staff person B, the home's Quality Improvement Specialist, Licensed Practical Nurse, Certified Brain Injury Specialist, Personal Care Home Administrator, and an American Red Cross First Aid/CPR/AED Instructor, provided First Aid/CPR training certifications to multiple staff who did not adequately complete the hands-on practice portion of the training, to include staff person C and staff person D.

Plan of Correction

Directed [REDACTED] - 12/24/2024)

The program brought in outside CPR trainers 12/14/24 - 12/20/24.

63b - Current First Aid Training (continued)

At this time all programs have at least one CPR/FA Certified staff member on each shift.

The program will work with an outside entity to ensure training compliance following hire and bi-annually as required.

HR runs monthly Certification reports that are sent to the program; these will be reviewed and monitored monthly by the Supervisors and Program Director to ensure compliance.

The Executive team will meet daily X 1 month to review compliance; this meeting will be titrated down based on compliance

Proposed Overall Completion Date: 12/24/2024

Directed:

By 1/31/25, all staff who were trained in first aid and certified in obstructed airway techniques and CPR and received this certification from [REDACTED] will be retrained and recertified by an individual other than [REDACTED], who is certified as a trainer, by a hospital, or other recognized health care organization. Documentation will be kept.

[REDACTED] 12/24/24

Directed Completion Date: 01/31/2025