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

April 4, 2025

████████, DIRECTOR
MILLCREEK MANOR
████████
████████

RE: LECOM PARKSIDE AT GLENWOOD
41 WEST GORE ROAD
ERIE, PA, 16509
LICENSE/COC#: 45384

Dear ████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/21/2024 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,
████████

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *LECOM PARKSIDE AT GLENWOOD* **License #**: *45384* **License Expiration**: *06/03/2025*

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

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

Administrator

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

Legal Entity

Name: *MILLCREEK MANOR*
Address:
Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/19/2002* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *75* **Waking Staff**: *56*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *11/21/2024*

Inspection Dates and Department Representative

11/21/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *50*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Secured Unit* **Capacity**: *16* **Residents Served**: *15*

Hospice

Current Residents: *6*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *50*
Diagnosed with Mental Illness: *5* **Diagnosed with Intellectual Disability**: *2*
Have Mobility Need: *25* **Have Physical Disability**: *1*

Inspections / Reviews

11/21/2024 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *12/20/2024*

12/23/2024 - POC Submission

Submitted By: **Date Submitted**: *03/31/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/02/2025*

Inspections / Reviews *(continued)*

01/06/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *03/31/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission* **Follow-Up Date**: *03/31/2025*

04/04/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *03/31/2025*
Reviewer: [redacted]
Follow-Up Type: *Not Required*

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

Direct care staff ■ the home's administrator, completed 7 hours of training during the October 2023 through September 2024 training year.

Plan of Correction ***Accept (■ - 01/06/2025)***

The administrator attended trainings on 11/22/24 and 11/23/24 and will continue to attend trainings including dementia trainings quarterly. Dementia trainings are scheduled for 1/13/25, 4/3/25, 7/1/25, 10/2/25 and will be conducted onsite at Glenwood. ■ ■ will provide education. Reservations have already been made by administrator in October 2024 for the LECOM educational series to be held May 13th and 14th 2025.The administrator will keep a log of all educational trainings and will review with supervisor on monthly basis beginning 1/1/25 to ensure compliance with regulation.

Licensee's Proposed Overall Completion Date: *03/03/2025*

Implemented (■ - 04/04/2025)

65e - 12 Hours Annual Training

2. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff B, hired ■, did not receive 12 hours of training during the January 2023 to December 2023 training year.

Direct care staff C, hired ■ did not receive 12 hours of training during the January 2023 to December 2023 training year.

Plan of Correction ***Accept (■ - 01/06/2025)***

All employee files will be audited by administrative assistant or designee by January 31st, 2025, to determine if employees annual training is completed.
Direct care staff B and C will be assigned trainings in Collins learning and will complete the 12 hours required by March 31st 2025. Fire education will be provided by maintenance director, administrator or designee prior to March 31st 2025. Education logs for all employees will be kept by administrative assistant

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (■ - 04/04/2025)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics *(continued)*

Description of Violation

Direct care staff B, hired [redacted] did not receive training during the January 2023 to December 2023 training year in the following content areas: Medication self-administration training, Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, Care for residents with dementia and cognitive impairments, Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, Personal care service needs of the resident, Safe management techniques, Care for residents with mental illness or an intellectual disability.

Direct care staff C, hired [redacted] did not receive training during the January 2023 to December 2023 training year in the following content areas: Medication self-administration training, Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan, Care for residents with dementia and cognitive impairments, Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration, Personal care service needs of the resident, Safe management techniques, Care for residents with mental illness or an intellectual disability.

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

Beginning 12/31/24 the administrative assistant or designee will audit all current DCW files to ensure that the requirements are being met.
DCW B and DCW C will complete the annual required education as assigned in Collin's learning. Dementia care trainings are scheduled 1/13/25. 4/3/25, 7/21/25 and 10/2/25 presented by [redacted]. All staff will be attending trainings on those dates.
Administrative assistant, HR assistant or designee will keep a log for each staff person and report any missing education ongoing to administrator or designee.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented ([redacted] - 04/04/2025)

65g - Annual Training Content

4. 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

Direct care staff B, hired [redacted] did not receive training during the January 2023 to December 2023 training year in the following content areas: Fire safety completed by a fire safety expert, Emergency preparedness procedures and recognition and response to crises and emergency situations, Resident rights, The Older Adult Protective Services Act, Falls and accident prevention.

Direct care staff C, hired [redacted] did not receive training during the January 2023 to December 2023 training year in the following content areas: Fire safety completed by a fire safety expert, Emergency preparedness procedures and recognition and response to crises and emergency situations, Resident rights, The Older Adult Protective Services Act, Falls and accident prevention.

65g - Annual Training Content (continued)

Plan of Correction ***Accept (█ - 01/06/2025)***

Beginning 12/31/24 the administrative assistant or designee will audit all current DCW files to ensure that the requirements are being met.
DCW B and DCW C will complete the annual required education as assigned in Collin's learning and attend mandatory staff meetings monthly to meet the requirements. DCW staff that fail to complete these trainings as well as education that will be provided at monthly staff meetings. Trainings will be provided by area agency on aging, physical and occupational therapists, fire experts or designees.
Beginning 1/1/25 administrative assistant, HR assistant or designee will keep a log for each staff person and report any missing education ongoing to administrator or designee.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

81b - Resident Personal Equipment

5. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

There was an uncovered bed side enabler on the left side of the resident's bed in bedroom #119 bed. There was an open space measuring approximately 4 x 6 inches in area. The enabler's covering was partially slid down.

Plan of Correction ***Accept (█ - 01/06/2025)***

All staff were educated on the proper use of bed mobility enablers on January 2,2025 by administrator. DON or designee will update all RASPS to include need for bed enabler as well as obtain a physician's order. Housekeeping will launder covers monthly. Maintenance director or designee will check proper placement and functionality monthly X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

82a - Poisonous Materials

6. Requirements

2600.
82.a. Poisonous materials shall be stored in their original, labeled containers.

Description of Violation

In the basement hot water room there was an unlabeled clear plastic spray bottle containing a green liquid approximately 1 inch full with words "carpet stain treat" written in marker.

Plan of Correction ***Accept (█ - 01/06/2025)***

Effective 12/19/24 all bottles of cleaners have labels and are in the SDS binder. All bottles with chemical cleaners are to be kept in the locked housekeeping closet. All staff were educated on the safe storage of cleaning products by administrator at January 2nd staff meeting. No chemical cleaners are to be stored in any other area of the

82a - Poisonous Materials (continued)

building. Maintenance Director or designee will audit the housekeeping closet to ensure all bottles are labeled and stored properly for 3 months beginning 1/1/25 to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

85a - Sanitary Conditions

7. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

In bedroom #240, there was a bedside urinal 1/3 full of urine on the resident's bedside dresser. The bedside urinal was approximately 18 inches from several Styrofoam cups of coffee, one of the coffee cups was full and without a lid.

There was a dark stain under the refrigerator on the carpet in bedroom #240

Plan of Correction ***Accept (█ - 01/06/2025)***

All staff were educated on the importance of maintaining sanitary conditions in resident care areas during the January 2nd staff meeting by administrator. Specifics on room trays and urinals not being placed near each other, and that any carpet that may have spills or have an odor will be cleaned by housekeeping or designee. Beginning 1/2/25 all occupied rooms will be checked daily by housekeeping staff or designee. A log will be kept monthly X 3 months to ensure compliance. Note: Resident residing in room 240 was discharged to a higher level of care. Room 240 had carpet removed and vinyl plank tile placed on floors.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

85d - Trash Receptacles

8. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

The left side door of the left blue dumpster was open. There were approximately four 40-gallon garbage bags of trash in the dumpster.

Plan of Correction ***Accept (█ - 01/06/2025)***

All staff were educated on January 2nd, 2025, at the staff meeting by administrator that all doors to the dumpsters must be closed and all garbage must be in the dumpster.
All staff were educated that effective January 3rd, 2025, that each person taking trash to the dumpster is to make sure all garbage is inside the dumpster.
Effective 1/3/25 maintenance director or designee will monitor trash cans/dumpsters weekly x 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

85d - Trash Receptacles *(continued)*

Implemented (█ - 04/04/2025)

85e - Trash Outside Home

9. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

There was a 40-gallon stainless steel garbage can overflowing with trash in the home's large gazebo. There were also various items of trash on the ground immediately next to the garbage can.

Plan of Correction ***Accept (█ - 01/06/2025)***

All staff were educated on January 2nd, 2025, staff meeting by administrator or that the 40 gallon trash can previously in the employee gazebo was removed and that all garbage must be thrown out inside the building effective immediately. Effective 1/3/25 maintenance director or designee will monitor the gazebo area to ensure ongoing compliance (as weather permits) weekly X 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

88a - Surfaces

10. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

There was a ceiling tile missing from the left side of the ceiling immediately next to the point of egress granting access to the home secured unit.

Repeat Violation: 9/7/23

Plan of Correction ***Accept (█ - 01/06/2025)***

Maintenance director corrected the ceiling tile during survey. All staff were educated on proper placement of ceiling tiles January 2, 2025, by the administrator. Beginning 1/3/25 all staff were educated to report any missing tiles immediately to supervisor. Beginning 1/3/25 maintenance director or designee will check ceilings weekly x 3months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

103e - Left Overs

11. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

103e - Left Overs *(continued)*

Description of Violation

There were two unlabeled and undated blocks of sliced American cheese in the home's walk in refrigerator.

Plan of Correction ***Accept (█ - 01/06/2025)***

All dietary staff were educated on 11/22/24 and again on 1/2/2025 that any foods that have been opened need to be dated. If food items are open in storage and are undated, they are to be discarded. Beginning January 2, 2025, dietary manager or designee will monitor daily x 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

132c - Fire Drill Records

12. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record does not record the date/time and the length in minutes and seconds of multiple fire drills to include:

**11/15/24 – no time of drill or evacuation time recorded*

**10/16/24 – 215 – 6 minutes*

**9/17/24 – 10 a.m. – 6 minutes*

**8/20/24 - 2:45 p.m. – 7 minutes*

**April – 10:30 – 11 minutes*

**March – 2 p.m. – 4 minutes*

**1/19/24 – 5:37 – 9 minutes*

Plan of Correction ***Accept (█ - 01/06/2025)***

All staff were educated on 1/2/25 staff meeting on fire drill documentation requirements by administrator. Beginning 1/3/25 maintenance director, administrator or designee will ensure that all aspects of the fire drill documentation are documented per regulations.
Maintenance director and administrator will document fire drill per regulation. Director of operations will monitor monthly X 3months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (█ - 04/04/2025)

132d - Evacuation

13. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

132d - Evacuation *(continued)*

Description of Violation

The home's safe evacuation time is 10 minutes. However, the fire drill record indicates that the fire drill conducted in April 2024 at 10:30 had an evacuation time of 11 minutes.

Repeat Violation: 9/7/23

Plan of Correction ***Accept (- 01/06/2025)***

All staff were educated on January 2. 2025 0n fire drill procedure. Fire drill documentation will include date and time of drill, length of drill as well as location of fire and routes of evacuation. The fire drill conducted on 1/31/15 was documented per regulation. Alternate fire routes were utilized. Maintenance director or designee will monitor monthly x 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

132f - Alternate Exit Routes

14. Requirements

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

The home failed to alternate exits during fire drills conducted on the following dates/times:
12/14/23 – each hallway
1/19/24 – each hallway
2/19/24 – out each hallway
7/16/24 – down all halls
8/20/24 – down all halls
9/17/24 – out halls and front door
10/16/24 – end of halls

Plan of Correction ***Accept (- 01/06/2025)***

All staff were educated by administrator on January 2nd staff meeting. Fire drill documentation will include date and time of drill, length of drill as well as location of fire and routes of evacuation.
Maintenance director and administrator or designee will document evacuation routes per regulation. Director of Operations will monitor monthly X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

141a 1-10 Medical Evaluation Information

15. Requirements

2600.

141a 1-10 Medical Evaluation Information *(continued)*

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1 has an enabler bar attached to their bed. However, there is no physician order indicating the purpose of the device or how it will meet the resident's care need.

Plan of Correction ***Accept (- 01/06/2025)***

All staff were educated Jan 2nd, 2025, by the administrator on the use of a bed enabler, including the need for an order as well as documentation on the DME and on the RASP. Effective January 3, 2025, DON or designee will monitor weekly x 3 months to ensure compliance. Housekeeping to wash enablers monthly and PRN. Maintenance director or designee to monitor appropriate placement monthly X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

183d - Prescription Current

16. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

Resident #2 was prescribed vitamin D3 tab 125 mcg give 1 tablet by mouth daily. The medication was discontinued on 9/30/24. However, the medication was present in the home's first floor medication cart.

Plan of Correction ***Accept (- 01/06/2025)***

All nursing staff were educated Jan 2nd by administrator on removing all medication from the med cart when medications are discontinued. Staff were educated that when they obtain an order to remove the medication from the cart and returned to pharmacy or destroyed. DON or designee will conduct med cart audits on Wednesdays X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

184a - Resident's Meds Labeled

17. Requirements

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

184a - Resident's Meds Labeled *(continued)*

Description of Violation

Resident #1 is ordered hydrocodone tab 5 – 325 mg take 1 tablet by mouth at bedtime for pain. However, the medication's label indicated hydrocodone tab 5 – 325 mg give 1 tablet by mouth twice daily as needed.

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

Plan of Correction ***Accept (- 01/06/2025)***

All nurses and CMT staff were educated by the administrator on January 2nd staff meeting on the importance of the medication label matching the medication order in MAR. Effective 1/3/25 if the label and order do not match nursing staff will notify the pharmacy immediately. If appropriate a direction changed sticker will be placed on the medication, if not appropriate the medication will be removed from med cart and pharmacy will send the corrected label. LPNS that complete cycle fill matches all cards placed in the cart with the order in PCC. DON or designee will complete cart audit weekly on Wednesdays X 3 months to ensure compliance and to be sure that all meds are available and match.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

185a - Implement Storage Procedures

18. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #1's glucometer was not calibrated to the correct date and time.

Resident #1 is prescribed enema disposable rectal enema insert 1 application rectally as needed for constipation. However, the medical device was not present in the home.

Resident #1 is prescribed Novolog flex pen subcutaneous solution 100 unit/ml - inject as per sliding scale: 0 - 69 = 0, 70 - 130 = 0, 131 – 180 = 1, 181 - 240 = 2, 241 - 300 = 3, 301 - 350 = 4, 351 - 400 = 5, 401 - 900 = 6 and call MD, subcutaneously three times a day. However, there were multiple missing and incorrect blood glucose readings recorded on the resident's November 2024 Medication Administration Record (MAR) on multiple dates and times to include:
**11/18/24 - MAR indicated 178 at 1700 however the glucometer indicated 171 at 5:50 p.m.*
**11/13/24 - MAR indicated 157 at 0700 however the glucometer indicated 180 at 10:09 p.m.*

Resident #1 is prescribed nystatin external cream apply to growing topically every day and evening shift at 7:00 a.m., and 3:00 p.m. for excoriation/yeast. However, the medication was not present in the home.

Repeat Violation: 9/7/23

Plan of Correction ***Accept (- 01/06/2025)***

All nurses and CMTs were educated Jan 2, 2025 on the importance of calibrating glucometers to the correct date and time. Beginning 1/3/25 trainings will be conducted by administrator or designee on how to change date/time on glucometers, as well as being educated that the readings on the glucometer must match all documentation in the MAR. DON or designee will audit glucometer settings and readings documented in MAR weekly X 3months to

185a - Implement Storage Procedures (continued)

ensure compliance. All PRN medications and treatments will be available for use when resident has an order, DON or designee will conduct cart audits on Wednesday X 3 months to ensure all PRN medications and treatments are available when ordered. DON or designee to conduct cart audits weekly on Wednesdays x 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

187d - Follow Prescriber's Orders

19. Requirements

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

Description of Violation

Resident #1 is prescribed nystatin external cream apply to growing topically every day and evening shift at 7:00 a.m., and 3:00 p.m. for excoriation/yeast. However, the medication was not present in the home and had not been administered to the resident.

Plan of Correction ***Accept (- 01/06/2025)***

All nursing staff were educated Jan 2nd at staff meeting on the importance of having medications available for residents when there is a physician order by administrator, and that if a medication is not available, they will notify the pharmacy immediately so it can be obtained. If medication/treatment is not available when ordered they must inform DON or designee immediately. DON or designee will contact pharmacy director to obtain medication, DON or designee to complete audits weekly on Wednesday X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

224a - Preadmission Screen Form

20. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3's pre-admission screen, dated is incomplete. Part III: Determination is blank.

Plan of Correction ***Accept (- 01/06/2025)***

Resident #3's prescreener was corrected immediately upon inspection. Beginning January 2nd all nurses will be educated that all preadmission screens are completed in entirety. Beginning 1/3/25 administrative assistant or designee will audit all charts to check all prescreens. DON or designee will monitor prescreens monthly X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented (- 04/04/2025)

225a - Assessment 15 Days

21. Requirements

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

Description of Violation

Resident #1 has an enabler bar attached to their bed. However, this device is not addressed on the resident's assessment and support plan, dated [redacted], indicating the purpose of the device or how it will meet the resident's care need.

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

All staff were educated on the proper use of bed mobility enablers on January 2,2025 by administrator. DON or designee will update all RASPS to include need for bed enabler as well as obtain a physician's order. Beginning 1/3/25 an audit of all residents that currently have a bed enabler on their bed have had their RASP updated by DON or designee. Effective 1/3/25 housekeeping, DCW and laundry staff will notify DON or designee if they see a bed enable on a resident's bed. DON or designee will ensure that the bed enabler was placed properly and obtain order and add to RASP. If the enabler is not placed properly maintenance director or designee will correct installation and notify DON or designee to obtain order (if appropriate) If not appropriate or no order the enabler will be removed, and family will need to remove from facility. DON or designee will audit all enablers weekly X 3 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *03/31/2025*

Implemented ([redacted] - 04/04/2025)

236 - Staff Training

22. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff B, hired [redacted] and works in the Secure Dementia Care Unit, did not receive training in dementia care during the January 2023 to December 2023 training year.

Direct care staff C, hired [redacted] and works in the Secure Dementia Care Unit, did not receive 12 hours of training in dementia care during the January 2023 to December 2023 training year.

Plan of Correction ***Accept ([redacted] - 01/06/2025)***

Effective January 1, 2025, all direct care staff will receive 12 hours of dementia care training annually. These trainings are scheduled 1/13/25, 4/3/25, 7/21/25, and 10/2/25, and will be presented by [redacted] Administrative assistant or designee will audit employee education files monthly X 6 months to ensure compliance.

Licensee's Proposed Overall Completion Date: *12/31/2025*

Implemented ([redacted] - 04/04/2025)