

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

May 12, 2025

[REDACTED]
MILLCREEK MANOR
[REDACTED]
[REDACTED]

RE: PARKSIDE SUITES/PARKSIDE AT
NORTH EAST
2 GIBSON STREET
NORTH EAST, PA, 16428
LICENSE/COC#: 44656

[REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/06/2025, 01/14/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

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

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: PARKSIDE SUITES/PARKSIDE AT NORTH EAST **License #:** 44656 **License Expiration:** 11/03/2024
Address: 2 GIBSON STREET, NORTH EAST, PA 16428
County: ERIE **Region:** WESTERN

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: MILLCREEK MANOR
Address: 5535 PEACH STREET, ERIE, PA, 16509
Phone: 8148444295 **Email:** KANDERSON@LECOMSLC.ORG

Certificate(s) of Occupancy

Type: Other **Date:** 10/18/1989 **Issued By:** Dept. of Labor & Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 51 **Waking Staff:** 38

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint, Incident **Exit Conference Date:** 01/14/2025

Inspection Dates and Department Representative

01/06/2025 On Site: [REDACTED]
01/14/2025 Off Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 70 **Residents Served:** 31

Secured Dementia Care Unit

In Home: Yes **Area:** 1st Floor **Capacity:** 18 **Residents Served:** 17

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 31
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 1
Have Mobility Need: 20 **Have Physical Disability:** 0

Inspections / Reviews

01/06/2025 - Partial

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 02/14/2025

Inspections / Reviews (*continued*)

02/24/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 03/03/2025

03/07/2025 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/10/2025

05/12/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/10/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

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 the afternoon of [REDACTED], staff person A walked into staff person B’s office and observed staff person B using a dropper to add [REDACTED] into a cup of apple juice. Staff person B indicated the apple juice was for resident [REDACTED]. After Staff person B gave resident [REDACTED] the juice, the resident vomited repeatedly and continued vomiting for several hours. Staff person B stated [REDACTED] tried to give [REDACTED] to resident [REDACTED] but the resident was throwing up and would not stop throwing up. Resident [REDACTED] is not prescribed [REDACTED] or [REDACTED], nor are these medications indicated on the resident’s October 2024 medication administration record (MAR). During the morning of 10/29/24, staff person A reported [REDACTED] observation to staff person C. However, the home did not report this incident to the Department until 10/31/24 at 2:25 PM.

Plan of Correction

Accept [REDACTED] - 03/07/2025)

Administrator and/or designee will reeducate the staff to report any suspected abuse or neglect of a resident to their supervisor immediately this includes verbal physical, financial or mental abuse and the homes shall report reportable incidents and conditions to the Department within 24 hours. Plan of Correction

. The reeducation will be done 1:1 with staff member starting 2/17/25 and ending 2/21/25. by the administrator and/or designee. We will interview 4 staff members 1x week for 2 weeks and then 1x for 4 months starting the week 2 starting 2/17/25.

Proposed Overall Completion Date: 02/26/2025

Licensee's Proposed Overall Completion Date: 02/26/2025

Implemented ([REDACTED] - 05/12/2025)

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

Resident [REDACTED] resides in the SDCU. [REDACTED] RASP, dated 11/20/24, indicates multiple diagnoses to include [REDACTED] [REDACTED] with [REDACTED], [REDACTED] unspecified, and [REDACTED] [REDACTED] RASP indicates [REDACTED] has moderate problems with irritability, judgement, agitation, aggression, and short-term memory and to meet these needs staff will give reminders, redirect, and provide one- on-one assistance.

Staff interviews indicate resident [REDACTED] hadn’t slept in days and staff were overwhelmed with [REDACTED] and [REDACTED] behaviors and were at their wit’s end. Staff person B stated [REDACTED] was trying to get an order of [REDACTED] for resident [REDACTED]. In a text conversation between staff person B and staff person D on [REDACTED] at 2:10 PM, staff person B stated, “Two droppers of CBD was given to our psycho lady this morning and [REDACTED] has been sleeping ever since. Feel free to give it again if [REDACTED] wakes up when you are here.” Staff person D replied, “Nice. Did you put it in a drink” to which staff person B replied, “Staff person E did lol...I just left, it’s so nice with [REDACTED] asleep.” Multiple text messages between staff person B, staff person C, and staff person D indicate they were conspiring to bring in additional medications to administer to the resident, such as liquid [REDACTED] and [REDACTED].

42b Abuse (continued)

On the afternoon of [REDACTED] staff person A walked into staff person B's office and observed staff person B using a dropper to add [REDACTED] into a cup of apple juice. Staff person B indicated the apple juice was for resident [REDACTED]. After Staff person B gave resident [REDACTED] the juice, the resident vomited repeatedly and continued vomiting for several hours. Staff person B stated [REDACTED] tried to give [REDACTED] to resident [REDACTED] but the resident was throwing up and would not stop throwing up. Resident [REDACTED] is not prescribed [REDACTED] or [REDACTED], nor are these medications indicated on the resident's October 2024 MAR.

Plan of Correction

Accept [REDACTED] 03/07/2025)

Staff member B, D and E were terminated on [REDACTED]. The following continue education have been assigned to all staff members, Abuse and Neglect in Health Care "What every Health care professional needs to know and Abuse elder justice and caregiver burnout. The education is done by [REDACTED] complete by March 10,2025. On March 11, 2025 at 2P a Inservice about abuse will be present by GECAC. Parkside North East will conduct a staff interview about will be done by administrator/ designee. We will interview 4 staff members 1x week for 2 weeks and than 1x for 4 months starting the week 2 starting 2/17/25.

Licensee's Proposed Overall Completion Date: 02/26/2025

Implemented [REDACTED] - 05/12/2025)

187d - Follow Prescriber's Orders

3. Requirements

2600.

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

Description of Violation

Resident [REDACTED] is prescribed [REDACTED], take 1 tablet by mouth 2 times daily for anxiety. However, this medication was not administered to resident [REDACTED] from 9:00 AM on [REDACTED] to 9:00 AM on [REDACTED] because the medication was not available in the home.

Plan of Correction

Accept [REDACTED] - 03/07/2025)

Resident [REDACTED] was given [REDACTED] 12/6/24 at 2000. Staff education on medication will be done on week 2/17/25 by the administrator and/or designee completed by 2/24/25. We will do a med audit 1x week for 4 weeks and 1x month for 4 months starting the week of 2/17/25.

Licensee's Proposed Overall Completion Date: 02/26/2025

Implemented [REDACTED] - 05/12/2025)

202 - Prohibitions

4. Requirements

2600.

202. The following procedures are prohibited:

1. Seclusion, defined as involuntary confinement of a resident in a room from which the resident is physically prevented from leaving, is prohibited. This does not include the admission of a resident in a secured dementia care unit in accordance with § 2600.231 (relating to admission).
2. Aversive conditioning, defined as the application of startling, painful or noxious stimuli, is prohibited.
3. Pressure point techniques, defined as the application of pain for the purpose of achieving compliance, is prohibited.
4. A chemical restraint, defined as use of drugs or chemicals for the specific and exclusive purpose of controlling acute or episodic aggressive behavior, is prohibited. A chemical restraint does not include a drug ordered by a physician or dentist to treat the symptoms of a specific mental, emotional or behavioral condition, or as pretreatment prior to a medical or dental examination or treatment.
5. Mechanical restraint, defined as a device that restricts the movement or function of a resident or portion of a resident's body, is prohibited. Mechanical restraints include geriatric chairs, handcuffs, anklets, wristlets, camisoles, helmet with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, papoose boards, restraining sheets, chest restraints and other types of locked restraints. A mechanical restraint does not include a device used to provide support for the achievement of functional body position or proper balance that has been prescribed by a medical professional as long as the resident can easily remove the device.
6. A manual restraint, defined as a hands-on physical means that restricts, immobilizes or reduces a resident's ability to move arms, legs, head or other body parts freely, is prohibited. A manual restraint does not include prompt escorting or guiding a resident to assist in the ADLs or IADLs.

Description of Violation

Resident [redacted] resides in the SDCU. [redacted] RASP, dated [redacted], indicates multiple diagnoses to include [redacted] with [redacted], [redacted] unspecified, and [redacted]. RASP indicates [redacted] has moderate problems with [redacted] and [redacted] and to meet these needs staff will give reminders, redirect, and provide one- on-one assistance.

Staff interviews indicate resident [redacted] hadn't slept in days and staff were overwhelmed with [redacted] and [redacted] behaviors and were at their wit's end. Staff person B stated [redacted] was trying to get an order of [redacted] for resident [redacted]. In a text conversation between staff person B and staff person D on [redacted] at 2:10 PM, staff person B stated, "Two droppers of [redacted] was given to our psycho lady this morning and [redacted] has been sleeping ever since. Feel free to give it again if [redacted] wakes up when you are here." Staff person D replied, "Nice. Did you put it in a drink" to which staff person B replied, "Staff person E did lol...I just left, it's so nice with [redacted] asleep." Multiple text messages between staff person B, staff person C, and staff person D indicate they were conspiring to bring in additional medications to administer to the resident, such as liquid [redacted] and [redacted].

On the afternoon of [redacted], staff person A walked into staff person B's office and observed staff person B using a dropper to add [redacted] into a cup of apple juice. Staff person B indicated the apple juice was for resident [redacted]. After Staff person B gave resident [redacted] the juice, the resident vomited repeatedly and continued vomiting for several hours. Staff person B stated [redacted] tried to give [redacted] to resident [redacted] but the resident was throwing up and would not stop throwing up. Resident [redacted] is not prescribed [redacted] or [redacted], nor are these medications indicated on the resident's October 2024 MAR.

Plan of Correction

Accept ([redacted] - 03/07/2025)

Staff Member B,D and E were terminated on [redacted] Staff education on chemical restraints will be done by Administrator and/or designee on the week of February 17 and completed by February 23,2025. Parkside North

202 - Prohibitions (continued)

will be conducting a staff interview about chemical restraints will be done by the administrator and/ or designee. We will interview 4 staff member 1x week for 4 weeks and 1x month for 4 months starting the week of 2/17/25 .

Licensee's Proposed Overall Completion Date: 02/26/2025

Implemented [REDACTED] 05/12/2025)