Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY PUBLIC

April 3, 2025

INTEGRACARE ERIE LLC
C/O INTEGRACARE CORP

RE: THE RESIDENCE AT PRESQUE ISLE BAY
1012 WEST BAYFRONT PARKWAY
ERIE, PA, 16507
LICENSE/COC#: 45350

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/27/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE RESIDENCE AT PRESQUE ISLE BAY* **License #**: *45350* **License Expiration**: *12/11/2024*

Address: *1012 WEST BAYFRONT PARKWAY, ERIE, PA 16507*

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

Administrator

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

Legal Entity

Name: *INTEGRACARE ERIE LLC*

Address:

Phone: **Email**:

Certificate(s) of Occupancy

Type: *I-2* **Date**: *09/02/2010* **Issued By**: *City of Erie*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *83* **Waking Staff**: *62*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *03/17/2025*

Inspection Dates and Department Representative

01/27/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *138* **Residents Served**: *62*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Life Stories* **Capacity**: *22* **Residents Served**: *12*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *62*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *21* **Have Physical Disability**: *0*

Inspections / Reviews

01/27/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/28/2025*

03/26/2025 - POC Submission

Submitted By: **Date Submitted**: *04/02/2025*

Reviewer: **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *04/02/2025*

Inspections / Reviews *(continued)*

04/03/2025 Document Submission

Submitted By: [redacted]
Date Submitted: *04/02/2025*
Reviewer: [redacted]
Follow Up Type: *Not Required*

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 [redacted] was sent out to hospital on [redacted] and returned on [redacted], at approximately 3:00 a.m., with a diagnosis of [redacted] This resident was prescribed [redacted], take 800mg by mouth every 12 hours for 5 days on 1/13/25; however, this medication was never administered to the resident. During this time, staff interviews indicated this resident was rarely getting out of bed and staff were having difficulty getting the resident to accept fluids or food intake. On [redacted], at approximately 7:20 a.m., resident [redacted] was found on the floor, near [redacted] bed, naked from the waist down, shivering and unresponsive. Staff interviews indicate when the resident was observed laying on the floor to also have a change in mental status and was sent to the hospital where the resident was admitted with the following diagnoses: [redacted], [redacted], and history of [redacted]. This resident remained in the hospital until [redacted] date of death, The cause of death was listed on the death certificate as [redacted] which caused the acute respiratory failure and the [redacted]

REPEAT VIOLATION: [redacted] et al, [redacted] et al, [redacted] et al

Plan of Correction ***Accept ([redacted] - 03/26/2025)***

Violation of 2600.42.b
Violation Description
Code Definition: A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Details: Resident [redacted] was sent out to hospital on [redacted] and returned on [redacted] at approximately 3:00 a.m., with a diagnosis of [redacted]. This resident was prescribed [redacted], take 800mg by mouth every 12 hours for 5 days on 1/13/25; however, this medication was never administered to the resident. During this time, staff interviews indicated this resident was rarely getting out of bed and staff were having difficulty getting the resident to accept fluids or food intake. On [redacted], at approximately 7:20 a.m., resident [redacted] was found on the floor, near [redacted] bed, naked from the waist down, shivering and unresponsive. Staff interviews indicate when the resident was observed laying on the floor to also have a change in mental status and was sent to the hospital where the resident was admitted with the following diagnoses: [redacted], and history of [redacted] This resident remained in the hospital until [redacted] date of death, and the cause of death was listed on the death certificate as [redacted] which caused the acute respiratory failure and the [redacted]. REPEAT VIOLATION: [redacted] et al, [redacted] et al, [redacted] et al.

Short Term Actions
1. Ensure Immediate Resident Safety and Medical Care
Short Term Actions
1. Immediate corrective action

42b - Abuse (continued)

1.1 Steps: • Resident is no longer a current resident, therefore no immediate resolution.
1.2 Responsible Party: Executive Operations Officer/Designee
1.3 Timeline: Effective Resident CTB

3. Staff Training on medication management and pharmacy communication
3.1 Goals: To retrain staff to ensure adherence to medication management and pharmacy communication.
3.2 Steps:
· Conduct a training session with all medication administration employees to ensure medications are on hand for all residents, and how to effectively communicate to the pharmacy.
· Training to also include recognizing signs and symptoms of illness warranting immediate medical attention.
· All new employees will have training as part of the on boarding process.
3.3 Responsible Party: Resident Wellness Director/ Designee
3.4 Time line: To be completed by 3/28/25

Licensee's Proposed Overall Completion Date: *03/28/2025*

Implemented - 04/03/2025)

187d - Follow Prescriber's Orders

2. Requirements

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

Description of Violation

Resident was sent out to hospital on and returned on at approximately 3:00 a.m., with a diagnosis of . This resident was prescribed take 800mg by mouth every 12 hours for 5 days on ; however, this medication was never administered to the resident. During this time, staff interviews indicated this resident was rarely getting out of bed and staff were having difficulty getting the resident to accept fluids or food intake. On , at approximately 7:20 a.m., resident was found on the floor, near bed, naked from the waist down, shivering and unresponsive. Staff interviews indicate when the resident was observed laying on the floor to also have a change in mental status and was sent to the hospital where the resident was admitted with the following diagnoses: , and history of This resident remained in the hospital until date of death, The cause of death was listed on the death certificate as which caused the acute respiratory failure and the
REPEAT VIOLATION et al

Plan of Correction ***Accept (- 03/26/2025)***

Violation of 2600.187.d
Violation Description
Code Definition: The home shall follow the directions of the prescriber.

187d - Follow Prescriber's Orders (continued)

Details: Resident [redacted] was sent out to hospital on [redacted] and returned on [redacted], at approximately 3:00 a.m., with a diagnosis of [redacted] This resident was prescribed [redacted], take 800mg by mouth every 12 hours for 5 days on [redacted]; however, this medication was never administered to the resident. During this time, staff interviews indicated this resident was rarely getting out of bed and staff were having difficulty getting the resident to accept fluids or food intake. On [redacted] at approximately 7:20 a.m., resident [redacted] was found on the floor, near [redacted] bed, naked from the waist down, shivering and unresponsive. Staff interviews indicate when the resident was observed laying on the floor to also have a change in mental status and was sent to the hospital where the resident was admitted with the following diagnoses: [redacted], [redacted], and history of [redacted]. This resident remained in the hospital until [redacted] date of death, and the cause of death was listed on the death certificate as [redacted] which caused the [redacted] and the [redacted]. REPEAT VIOLATION [redacted] et al.

Short Term Actions 1. Medication Provision Assurance
1.1 Goals: Ensure that all prescribed medications are available and administered to residents.
1.2 Steps:
• Conduct an immediate audit of all resident medication supplies to ensure availability.
• Order any missing medications and ensure delivery within 24 hours.
• Communicate with the pharmacy to confirm timely medication delivery schedules.
1.3 Responsible Party: Executive Operations Officer/Designee
1.4 Time line: To be completed by 3/28/25

Staff Training on Medication Policies

2.1 Goals: Educate staff on proper medication administration policies and prescriber directions.

2.2 Steps:
• Organize a training session for all MA/LPN staff on medication handling and administration including contacting pharmacy when a medication is not available to check on status and ensure that the medication will be available.
• Include instructions specific to timely ordering and maintenance of medication supplies.
• Any future newly hired/promoted MA/LPN team members will be educated on this as part of their onboarding.
2.3 Responsible Party: Executive Operations Officer/Designee
2.4 Time line: To be completed by 3/28/25

Long Term Actions 1. Daily Medication Exception Report Audit
1.1 Goals: Review med pass exceptions report daily for missed meds due to "med not available".
1.2 Steps:
• EOO/Designee will pull exception report from emar daily and audit for meds not administered due to "med not available" daily for 30-days
• Pharmacy will be contacted for any meds found to be unavailable for a status update and to ensure the medication will be available for the resident.
1.3 Responsible Party: Executive Operations Officer/Designee
1.4 Time line: Audits to begin on 3/28/25

Licensee's Proposed Overall Completion Date: *03/28/2025*

187d - Follow Prescriber's Orders *(continued)*

Implemented [redacted] - 04/03/2025)