pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **SARAH A REED RETIREMENT CENTER**
LEGAL ENTITY

To operate **SARAH REED SENIOR LIVING**
NAME OF FACILITY OR AGENCY

Located at **227 WEST 22ND STREET, ERIE, PA 16502**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **100** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 25**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **November 3,** **2025** until **May 3,** **2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **447611**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: NOVEMBER 3, 2025

[redacted]
Sarah A. Reed Retirement Center
227 West 22nd Street
Erie, Pennsylvania 16502

RE: Sarah Reed Senior Living
License/COC #: 447611

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing (Department) licensing inspections on April 17, 2025, April 18, 2025, and September 30, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby REVOKES your certificate of compliance (license number 44761) dated June 16, 2025 to June 16, 2026 and issues you a FIRST PROVISIONAL license to operate the above facility. A FIRST PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) ;(5) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your FIRST PROVISIONAL license is enclosed and is valid from NOVEMBER 3, 2025 to MAY 3, 2026.

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

If you disagree with the decision to issue a FIRST PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your FIRST PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

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.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc: [redacted]

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

Facility Information

Name: *SARAH REED SENIOR LIVING* **License #:** *44761* **License Expiration:** *06/16/2025*

Address: *227 WEST 22ND STREET, ERIE, PA 16502*

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

Administrator

Name: [redacted]

Legal Entity

Name: *SARAH A REED RETIREMENT CENTER*

Address: *227 WEST 22ND STREET, ERIE, PA, 16502*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *10/11/1994* **Issued By:** *Dept. of Labor & industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *88* **Waking Staff:** *66*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date:** *04/18/2025*

Inspection Dates and Department Representative

04/17/2025 - On-Site: [redacted]

04/18/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served:** *69*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *ZURN PAVILION* **Capacity:** *25* **Residents Served:** *19*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *69*

Diagnosed with Mental Illness: *1* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *19* **Have Physical Disability:** *0*

Inspections / Reviews

04/17/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/19/2025*

05/30/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *06/06/2025*

06/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/16/2025*

10/20/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/15/2025*

Reviewer: [redacted] **Follow-Up Type:** *Enforcement*

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

The assessment and support plan dated [redacted]/25 for resident #3 indicates that due to [redacted] dementia, the resident requires toileting assistance and staff will assist the resident to the bathroom every 2 hours and as needed. On the overnight shift [redacted]/25, the resident did not receive this assistance as required as [redacted] was sitting in [redacted] recliner chair in [redacted] room all night and staff did not assist [redacted] with toileting. When day shift staff arrived on the morning of 4/7/25 and went to provide care to resident #3, [redacted] was found still in [redacted] chair and saturated in urine with urine dripping from [redacted] nightgown and [redacted] brief.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

[redacted] *verified with Maintenance staff on 4/17/25 that bed shaker had been orderd. Maintenance Director confirmed order. Bed shaker for Resident #1 was installed on 5/13/2025 by Maintenance staff person. Operation of bed shaker will be checked every month by maintenance staff starting June 2025. This will be completed for as long as the resident resides in personal care. Maintenance Staff will retain monitoring record fror PCHA.*

[redacted] *2025, PCHA and PC Nurse Manager were made aware of incident on by staff member. Investigation of incident commended on 4/7/25 to determine which staff member did not provide incontinence care to Resident # 3. Staff member was off of the schedule immediately pending further investigation of incident. Investigation concluded on 4/21/25 and staff member was gvien a formal write up for the personnel file in addition to completing [redacted] suspension period and was returned ot [redacted] normal schedule. Electronic system for resdient tasks was updated by PCHA on 5/16/25 for residents requiring routine incontinence care. RASPs for these residents were also updated on 5/16/25 to reflect the new updates to support plans. Personal Care Aides will chart off completion of task every two hours. If incontinence care is not needed by residents, staff member will chart off "No", If rsident refuses assistance, staff member will chart off "resdient refused". If staff member provided incontinence care, satff member will chart off "Yes". Beginning 5/27/2025, Personal Care Home Administrator, or designee, will review completed care by aides, daily for 30 days, in Point Of Care , the electronic charting system that is used to ensure completion of all tasks. Then, a random sample of 10 residents will be selected weekly for 4 weeks, and electronic charting will be checked for accurate completion. Then, GERM cards will be randomly placed in 3 residents' rooms during 3rd shift for the next 4 weeks; this card will be brought to the LPN or Med Tech by on shift by the aide to show that the resident was checked for incontinence. See attached,*

Licensee's Proposed Overall Completion Date: *07/18/2025*

Implemented [redacted] - 10/20/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract dated [redacted]/24 for resident #2 was not signed by the resident.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

Signature for Resident # 2 was obtained for [redacted] admission agreement on [redacted]/25. See attached. Personal Care Home Administrator reviewed all admission agreements for current census of 94 residents on 5/15/2025 to ensure resident sigatures were present. Two admission agreements for residents from the secured dementia unit were not present at the [redacted] request due to inability to comprehend. Resident Services Coordinator will obtain these signtaures by 5/21/2025. PCHA will review all future admission agreements to ensure signtature of resident is present. PCHA will initial back of admission agreement with date reviewed. This will be ongoing.

Licensee's Proposed Overall Completion Date: *05/21/2025*

Implemented [redacted] - 10/20/2025)

42b - Abuse

3. 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]/25 at 9:00a.m. staff person A did not identify the correct resident during the medication pass and administered resident #5's medication to resident #4. Resident #4 suffered physical effects of receiving numerous medications not prescribed to her and was sent to the Emergency Room on [redacted]/25 at approximately 1:00p.m. due to low Blood Pressure. Resident #4 was admit to the hospital for Hypotension caused by being administered multiple incorrect medications. Resident #4 was discharged from the hospital on [redacted]25 and transferred to a Skilled Nursing Facility where [redacted] stayed until [redacted] was transferred back to the home on [redacted]/25.
Resident #4 received the following medications not prescribed to [redacted]
Amlodipine Besylate 5 mg, 1 tablet daily for Essential Hypertension., Bumetanide 1 mg, 1/2 tablet daily for Congestive Heart Failure.,
Isosorbide Mononitrate Extended Release 24-hour 30mg., 1 tablet daily for Congestive Heart Failure., Jardiance 10mg, 1 daily for Type 2 Diabetes., Lisinopril 10mg, 1 daily for Essential Hypertension., Loratadine 10 mg, 1 daily for Allergies., Omeprazole 20mg, 1 daily for Gastro-Esophageal Reflux., Preservision Areads 2 + COQ10, 1 daily Supplement., Raloxifene HCl 60mg, 1 daily for Osteoporosis., Simethicone Chewable 125mg, 1 daily for Gas Relief., Vitamin B-12 1000mcg, 1 daily for Supplement., Tylenol 325mg, 2 tablets 2 times daily for Discomfort.
Repeat Violation: 4/16/24 et al.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On [redacted]/25, LPN agency contract was cancelled. Beginning 4/3/2025, Personal Care Home Administrator, [redacted], re-educated all LPNs and Med Techs as to following proper medication adminstration procedures. See completion dates of re-education on staff acknowledgements. See attached. All new Med Techs or LPNs will be provided this memo by PCHA or designee to review and ackowledge. Beginning 6/1/2025, 5 weekly random medication administration observations of LPNs and Med Techs will be conducted RN PC Nurse Manager. This will

42b - Abuse (continued)

continue for 3 months. Then. 5 biweekly medication administration observations will be conducted by RN PC Nurse Manager for 3 months. Then 5 monthly random medication administration observations will be conducted by RN PC Nurse Manager for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2026*

42c - Treatment of Residents

4. Requirements

2600.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

The assessment and support plan dated [redacted]/25 for resident #3 indicates that due to her dementia, the resident requires toileting assistance and staff will assist the resident to the bathroom every 2 hours and as needed. On the overnight shift of 4/6/25, the resident did not receive this assistance as required as [redacted] was sitting in [redacted] recliner chair in [redacted] room all night and staff did not assist [redacted] with toileting. When day shift staff arrived on the morning of 4/7/25 and went to provide care to resident #3, [redacted] was found still in [redacted] chair, saturated in urine with urine dripping from [redacted] nightgown and [redacted] brief.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

Tasks for all residents requiring incontinence care were updated by PCHA on 5/16/25 to reflect the need for staff to check/perform incontinance care every 2 hours. Personal Care Aides will chart off completion of task every two hours. If incontinence care is not needed by residents, staff member will chart off "No", If resident refuses assistance, staff member will chart off "resident refused". If staff member provided incontinence care, staff member will chart off "Yes". Beginning 6/1/2025, Personal Care Home Administrator or designee will review completed care by aides, daily, in Point Of Care , the electronic charting system that is used to ensure completion of all tasks. Resident Assessment and Support Plans (RASPs) for 20 residents requiring incontinence care were updated on 5/15/2025 by Personal Care Home Administrator. Monitoring of task completion will be completed, daily, by Personal Care Home Administrator for 30 days, beginning 6/1/2025. Then, a random sample of 10 residents will be selected weekly for 4 weeks, and electronic charting will be checked for accurate completion. Then, GERM cards will be randomly placed in 3 residents' rooms during 3rd shift for the next 4 weeks; this card will be brought to the LPN or Med Tech by on shift by the aide to show that the resident was checked for incontinence. See attached,

Licensee's Proposed Overall Completion Date: *09/30/2025*

Implemented [redacted] - 10/20/2025)

82c - Locking Poisonous Materials

5. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

82c - Locking Poisonous Materials *(continued)*

Description of Violation

On 4/17/25 at 11:40a.m. in the home's Secure Dementia Care Unit, there was an unattended unsecured 1/4 full container of sanitizer and a 1/3 full container of pot and pan detergent located in the kitchen cabinet under the sink with a manufacture's label indicating "Keep out of reach, contact poison control if swallowed", was unlocked, unattended, and accessible to residents in the Secure Dementia Care Unit. Not all the residents of the home have been assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On 4/17/2025, bottles were immediately removed by Personal Care Home Administrator. Sign was posted on cabinet door. See attached. Beginning 6/1/2025, each shift leader in secured dementia unit will check the cabinet at the beginning of the shift, middle of the shift and end of the shift and document on tool. See attached. This will continue daily, through the end of August 2025.

Licensee's Proposed Overall Completion Date: *08/31/2025*

Implemented [redacted] - 10/20/2025)

85a - Sanitary Conditions

6. Requirements

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

Description of Violation

On 4/17/25, at approximately 11:36 a.m., there was a used blue razor and an unlabeled tube of TENA PROskin Cleansing Cream in an unlocked cabinet located in the common bathroom near the entrance of the home's Secure Dementia Care Unit directly across from the kitchen.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On 4/17/2025, Personal Care Home Administrator removed razor and skin soap immediately upon finding. Starting on 6/1/25, Shift Supervisors will check bathroom to make sure all supplies are in the bathroom cabinet and the bathroom cabinet is locked at the beginning of a shift and at the end of a shift throughout all three shifts. Shift supervisors will sign off on monitoring tool and monthly completion will be given to Personal Care Home Adminstrator. This will be completed for the next 90 days. See attached.

Licensee's Proposed Overall Completion Date: *08/30/2025*

Implemented [redacted] - 10/20/2025)

85e - Trash Outside Home

7. Requirements

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

85e - Trash Outside Home *(continued)*

Description of Violation

On 4/17/25 at approximately 12:20p.m., the door on the side of the dumpster located outside of the homes main kitchen was open approximately 4 ft. The dumpster was approximately 1/3 full of trash.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On 4/17/2025, Dietary Supervisor immediately closed the open dumpster door. Also on 4/17/2025, dietary supervisors began the daily monitoring of the door to ensure it was properly closed. It is checked several times through the day and evening. This tool will be used indefinately. See attached for April 2025 and May 2025 to date.

Licensee's Proposed Overall Completion Date: *05/20/2025*

Implemented [redacted] - 10/20/2025)

86b - Bathroom

8. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 4/17/25, at 11:13a.m., the continuous air draw vent in the common bathroom located diagonally across the hall from the ground floor beauty shop was not operational. There is no window in the bathroom.

On 4/17/2025, at 11:21a.m. the private bathroom located in resident room #11 did not have an operational continuous air draw vent. There is no window in the bathroom.

On 4/17/25, at 11:25a.m., the private bathroom located in resident room #2 did not have an operational continuous air draw vent. There is no window in the bathroom.

On 4/17/25 at 11:36 a.m., the continuous air draw vent located in the common bathroom located next to the main entrance and across from the kitchen was not operational. There is no window in the bathroom.

Plan of Correction ***Accept [redacted] 05/22/2025)***

It is not clear which bathroom was surveyed at 11:36 AM. The main entrance is on the ground floor but there is no kitchen. There is a bathroom on the 1st floor, across from the main kitchen, but there is no main entrance. If [redacted] was in the memory care unit, the bathroom is across from the kitchen but not next to the main entrance of the dementia unit. This location was not discussed in the exit conference.

On 4/18/2025, the roof top units were checked by facility maintenance staff for proper functioning. 1 motor in the exhaust hood was replaced on 4/18/2025 by facility maintenance staff. On 4/21/2025, contracted HVAC company was on site to initiate preventative maintenance procedures on all exhaust hoods. Two more motors were ordered on 4/23/2025. These three motors will be checked monthly by maintenance staff, indefinately. See attached.

Licensee's Proposed Overall Completion Date: *05/20/2025*

86b - Bathroom *(continued)*

Implemented [redacted]/20/2025)

103e - Left Overs

9. 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.

Description of Violation

At approximately 12:10p.m., there was a one third full bag of onion rings that had been previously opened in the homes walk-in refrigerator located in the main kitchen and there was no open date on the item.

Plan of Correction ***Accept ([redacted] - 05/22/2025)***

On 4/17/2025, the open bag of onion rings was not in the walk in refrigerator. It was in the walk in freezer as these items must remain frozen until used. Dietary Superisor immediately threw out the open bag of onion rings. Beginning on 4/17/25, the walk-In freezer is being checked by dietary supervisors, daily and throughout the shift, to ensure proper storage procedures are being followed. This will be continued indefinately. See attached for April 2025 and May 2025 to date.

Licensee's Proposed Overall Completion Date: *05/20/2025*

Implemented [redacted] - 10/20/2025)

103g - Storing Food

10. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 4/17/25, at approximately 12:15p.m., there were multiple 3-gallon ice cream containers that were uncovered and unsealed in the ice cream freezer in the home's main kitchen.

On 4/17/25 at approximately 12:10p.m., there was a 1/2 full bag of frozen boneless chicken breast that was opened and unsealed in the main walk-in freezer in the home's main kitchen.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On 4/17/2025, the lids were immediately placed on the open containers of ice cream by Dietary Supervisor. On 4/17/25, a sign was placed on the freezer to always keep lids on when not serving. See attached. On 4/17/25, dietary Supervisor created a monitoring tool for all dietary supervisors throughout the day and evening to continuously check the ice cream lids. See attached.
On 4/17/2025, Dietary Supervisor immediately threw out the open bag of chicken breasts. On 4/17/25, the walk in freezer is being checked by dietary supervisors, daily, to ensure proper storage procedures are being followed. See attached. This will be continued indefinately See attached for April 2025 and May 2025 to date.

Licensee's Proposed Overall Completion Date: *05/20/2025*

Implemented [redacted] - 10/20/2025)

131f - Fire Extinguisher Inspection

11. Requirements

2600.
131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

Description of Violation

The fire extinguisher in the home's vehicle used to transport residents has not been inspected by a fire safety expert since April 2023.

Plan of Correction ***Accept [redacted] - 06/27/2025)***

The fire extinguisher in the small van was inspected and tagged by Summit Fire and Security on 4/21/2025. See Attached. This fire extinguisher was also added to the annual fire extinguisher inspection list. See attached. The extinguishers are inspected monthy by Summit Fire.

On 4/18/2025, upon finding the expired inspection tag on the fire extinguisher in the van, [redacted], PCHA, removed the fire extinguisher and gave it to the Maintenance Director so that it could be schedueld for a proper inspection. [redacted], Maintenance Director, contacted Summit Fire to come ASAP to inspect the fire extinguisher. On 4/21/25, Summit Fire came to the facility and inspected the fire extinuisher and it was placed back in the van by Maintenance Director. This fire extinguisher was added to the monthly inspection sheet as indicated with attached document. Maintenance Director will review the monthly completion report after the inspections are completed by Summit Fire to ensure all inspections have been completed as scheduled. This will contionue for the next 12 months.

Licensee's Proposed Overall Completion Date: *06/02/2025*

Implemented [redacted] - 10/20/2025)

132a - Monthly Fire Drill

12. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

Although the homes fire drill logs document drills, an unannounced fire drill was not held during the months of 9/24, 6/24 and 2/25 because no alarm was activated and no residents were evacuated.

Plan of Correction ***Directed [redacted] - 06/18/2025)***

On 4/21/2025, PCHA met with Maintenance Director to re-educate on what "sleeping drill" means as the regulation is different that DOH regulation.

A new schedule of fire drills for the remainder of the year was created by Maintenance Director and active alarm will accompany all sleeping drills. See attached schedule of fire drills throughout the remainder of 2025.

Maintenance Director will send monthly drill report to PCHA so that PCHA can review and ensure that all regulations were met for monthly drill. If regaulations were not met, PCHA will ask Maintenance Driector to

132a - Monthly Fire Drill (continued)

conduct another drill in the same month. PCHA will keep all completed drills. These records will be monitored for the next year.

Proposed Overall Completion Date: 03/09/2026

Directed:
By 7/15/25, the maintenance director will send monthly drill reports to the PCHA as indicated above. Documentation will be kept.
[redacted] ***6/27/25***

Directed Completion Date: *07/15/2025*

Implemented [redacted] ***- 10/20/2025)***

132c - Fire Drill Records

13. 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 for the drills conducted from January 2025 through March 2025 do not include the calendar year.

Plan of Correction ***Directed*** [redacted] ***- 06/27/2025)***

On 4/22/2025, Personal Care Home Administrator added the calendar year for the January 2025, February 2025, and March 2025 fire drills. See attached.

On 4/22/25, Maintenance Director created a schedule of monthly fire drills through the end of 2025 and all scheduled dates reflect the proper calendar year. See attached.

Completed monthly fire drill record will be sent to PCHA by Maintenance Director, prior to the end of each month, to ensure complaince with fire drill regulations. If drill did not meet regulations, PCHA will ask Mainatenance Director to schedule another drill fo the month so that the error is corrected and meets compliance. This will be done monthly for the next year.

Proposed Overall Completion Date: 03/09/2026

Directed:
By 7/15/25, the maintenance director will send monthly drill reports to the PCHA as indicated above. Documentation will be kept.
[redacted] ***6/27/25***

132c - Fire Drill Records (continued)

Directed Completion Date: *07/15/2025*

Implemented [redacted] - 10/20/2025)

132e - Fire Drill Sleeping Hours

14. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 3/29/24 at 4:30a.m. The sleeping hour fire drills held on 9/14/24 at 5:00a.m. and 6/14/24 at 4:30a.m. failed to evacuate any residents.

Plan of Correction ***Directed [redacted] - 06/27/2025)***

On 4/21/2025, PCHA met with Maintenance Director to re-educate on what "sleeping drill" means as the regulation is different that DOH regulation.

A new schedule of fire drills for the remainder of the year was created by Maintenance Director and an active alarm will accompany all sleeping drills and residents in affected drill areas will be evacuated. See attached schedule of fire drills throughout the remainder of 2025.

PCHA will review completed monthly fire drill record that is submitted by Maintenance Director. If record does not meet regulations, PCHA will ask Maintenance Director to schedule another drill for the month. This will continue monthly for the next 12 months.

Proposed Overall Completion Date: 04/20/2026

Directed:
By 7/15/25, the maintenance director will send monthly drill reports to the PCHA as indicated above. Documentation will be kept.
[redacted] 6/27/25

Directed Completion Date: *07/15/2025*

Implemented [redacted] - 10/20/2025)

132f - Alternate Exit Routes

15. Requirements

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

Description of Violation

The fire drill logs for the fire drills conducted from 12/10/24, through 3/22/25, indicated the same routes of evacuation for every fire drill held in the home.

132f - Alternate Exit Routes (continued)

Plan of Correction ***Directed [redacted] - 06/27/2025)***

On 4/21/25, PCHA reviewed fire drill records from 1/24-3/25. Based upon the location selected that month for the drill, as indicated on the fire drill record, PCHA updated the drill record to reflect which exit was used. See attached.

On 4/21/2025, PCHA met with Maintenance Director to re-educate on how exit routes should be listed on the fire drill report. A new schedule of fire drills for the remainder of the year was created by Maintenance Director and specific exit routes have been selected and will be used future drills , rather than listing all possible exit routes. See attached schedule of fire drills throughout the remainder of 2025.

PCHA will review completed monthly fire drill record each month, to ensure that specific exit routes are listed and were used. This will continue for the next 12 months,

Proposed Overall Completion Date: 04/20/2026

Directed:
By 7/15/25, the PCHA will review completed monthly fire drills indicated above. Documentation will be kept.
[redacted] 6/27/25

Directed Completion Date: *07/15/2025*

Implemented [redacted] - 10/20/2025)

132h - Designated Meeting Place

16. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 1/15/24 at 10:45a.m., there were 61 residents in the building, however only 57 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 2/21/24 at 1:00p.m., there were 63 residents in the building, however only 60 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 3/29/24 at 4:30a.m., there were 64 residents in the building, however only 61 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 4/4/24 at 6:06a.m., there were 64 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 5/8/24 at 3:00p.m., there were 67 residents in the building, however only 5 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 6/14/24 at 4:30a.m., there were 67 residents in the building, however 0 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 7/20/24 at 9:15a.m., there were 71 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

132h - Designated Meeting Place (continued)

During the fire drill on 8/17/24 at 3:15p.m., there were 70 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 9/11/24 at 5:00a.m., there were 69 residents in the building, however 0 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 10/29/24 at 6:55a.m., there were 70 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 11/3/24 at 6:20p.m., there were 70 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 12/10/24 at 11:00p.m., there were 66 residents in the building, however only 12 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 1/10/25 at 12:00p.m., there were 72 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 2/21/25 at 2:00p.m., there were 70 residents in the building, however 0 residents evacuated to a designated meeting place away from the building or within the fire-safe area.
During the fire drill on 3/22/25 at 11:41p.m., there were 69 residents in the building, however only 20 residents evacuated to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction ***Directed [redacted] - 06/27/2025)***

On 3/21/2023, the City of Erie Fire Inspector presented the facility with a letter stating that we are not required to fully evacuate the building during a fire drill due to the fact the building is fully sprinklered and has fire safe areas throughout the facility. We were instructed to only evacuate the affected area of the drill. Please see attached.

I emailed you previously to see if this letter was accepted as rationale to why not all residents are evacuated during our drills. I was awaiting clarification to determine if a plan of correction was necessary. Please advise.

Proposed Overall Completion Date: 06/04/2025

Directed:
§2600.132(h) requires that all residents evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill, indicating the regulatory intent for residents to congregate in the designated meeting place away from the building or within the fire safe areas during each fire drill. This is not possible if each resident is in [redacted] own room.

By 7/15/25, the administrator will reeducate all staff and residents regarding the requirement that all residents are to evacuate to a designated meeting place away from the building or within the fire-safe areas during each fire drill. Documentation will be kept.

By 7/15/25 and monthly thereafter, the PCHA will audit the home's fire drill records to ensure all residents are evacuated to a designated meeting place away from the building or within the fire-safe areas during each fire drill. Documentation will be kept.

[redacted] 6/27/25

Directed Completion Date: *07/15/2025*

Not Implemented [redacted] - 10/20/2025)

181c - Self-administration Assessment

17. Requirements

2600.
181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On 4/17/25, at 12:30p.m. resident #4 had a partially used tube of Nystatin cream on the sink in [redacted] bathroom, however, the resident has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self-administer and the need for reminders to take medications.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On 4/17/25, PCHA asked Resident # 4 if [redacted] would like to continue to self-administer the Nystatin Cream. Resident stated Yes. On 5/20/25, PC Coordinator contacted PCP office to obtain order to self-administer the Nystatin Cream. On 5/23/2025, a letter will be mailed to all resdients and family members that the Resident Services Office must be contacted to obtain approval and PCP order for any medication that is given to a resident to self-administer. This letter also noted that residents' apartments would be visited by a member of the Resdient Services Office to see if any medications exist that do not have an order or that do not have an order to self-administer. These apartment checks will begin the week of 6/1/25 and will continue monthly for the next 12 months.

Licensee's Proposed Overall Completion Date: *05/20/2025*

Not Implemented [redacted] - 10/20/2025)

182c - Medication Administration

18. Requirements

2600.
182.c. Medication administration includes the following activities, based on the needs of the resident:
1. Identify the correct resident.

Description of Violation

On [redacted]9/25 at 9:00a.m. staff person A did not identify the correct resident during the medication pass and administered resident #5's medication to resident #4. Resident #4 suffered physical effects of receiving numerous medications not prescribed to [redacted] and was sent to the Emergency Room on [redacted]/25 at approximately 1:00p.m. due to low Blood Pressure. Resident #4 was admit to the hospital for Hypotension caused by being administered multiple incorrect medications. Resident #4 was discharged from the hospital on [redacted]25 and transferred to a Skilled Nursing Facility where [redacted] stayed until [redacted] was transferred back to the home on [redacted]/25.
Resident #4 received the following medications not prescribed to [redacted]
Amlodipine Besylate 5 mg, 1 tablet daily for Essential Hypertension., Bumetanide 1 mg, 1/2 tablet daily for Congestive Heart Failure.,
Isosorbide Mononitrate Extended Release 24-hour 30mg., 1 tablet daily for Congestive Heart Failure., Jardiance 10mg, 1 daily for Type 2 Diabetes., Lisinopril 10mg, 1 daily for Essential Hypertension., Loratadine 10 mg, 1 daily for Allergies., Omeprazole 20mg, 1 daily for Gastro-Esophageal Reflux., Preservision Areads 2 + COQ10, 1 daily Supplement., Raloxifene HCl 60mg, 1 daily for Osteoporosis., Simethicone Chewable 125mg, 1 daily for Gas Relief., Vitamin B-12 1000mcg, 1 daily for Supplement., Tylenol 325mg, 2 tablets 2 times daily for Discomfort.

182c - Medication Administration (continued)

Plan of Correction ***Accept [redacted] - 05/22/2025)***

On [redacted]25, LPN agency contract was cancelled. Beginning 4/3/2025, Personal Care Home Administrator, [redacted] re-educated all LPNs and Med Techs as to following proper medication administration procedures. See completion dates of re-education on staff acknowledgements. See attached. All new Med Techs or LPNs will be provided this memo by PCHA or designee to review and ackowledge. Beginning 6/1/2025, 5 weekly random medication administration observations of LPNs and Med Techs will be conducted by RN PC Nurse Manager. This will continue for 3 months. Then. 5 biweekly medication administration observations will be conducted by RN PC Nurse Manager for 3 months. Then 5 monthly random medication administration observations will be conducted by RN PC Nurse Manager for 3 months.

Licensee's Proposed Overall Completion Date: *03/31/2026*

183b - Meds and Syringes Locked

19. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/17/25 at 12:17p.m. in resident #1's room there was an opened tube of Triamcinolone .1%, apply cream topically over twelve hours to lower extremities for rash until cleared. This medication was not secured.

On 4/17/25, at 11:50 p.m., resident #2 had a partially used container of Perianal Cleansing Topical to use for cleansing after voiding and bowel movement on the sink in [redacted] private bathroom. This medication was not secured.

On 4/17/25, at 12:30p.m. resident #4 had a partially used tube of Nystatin cream on the sink in [redacted] bathroom. This medication was not secured.

Plan of Correction ***Directed [redacted] - 06/27/2025)***

On 4/17/2025, PCHA, [redacted], requested that resident # 1, #2, and # 4 put the open medication in their medicine cabinet in their bathrooms so that the medication was immediately secured. The residents all complied.

An automated phone message will be sent to all residents on 6/3/25 by PCHA to remind them that all medications in their apartments must be securely stored as described in the facility's home rules and in the admisison agreements.

Beginning 6/1/25, Resident Services staff will visit all personcal care residents to determine whether or not medications exist in their apartments as compared to active physician orders. This staff will also present to the resident a statement of acknowledgement that medications must be in a secured location in their apartment. Resident apartments will be checked by Resident Services staff monthly for 3 months, then quarterly for the next year.

183b - Meds and Syringes Locked (continued)

Proposed Overall Completion Date: 03/09/2026

Directed:
by 7/15/25, Resident Services staff will visit all personal care residents as indicated above. Documentation will be kept.
[redacted] ***6/27/25***

Directed Completion Date: *07/15/2025*

Not Implemented [redacted] ***- 10/20/2025)***

183d - Prescription Current

20. 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

On 4/17/25 at 12:17p.m. in resident #1's room there was an opened tube of Triamcinolone .1 percent apply cream topically over twelve hours to lower extremities for rash until cleared, however, the medication was discontinued on 12/30/24.

On 4/17/25, at 12:03p.m. resident #6 had an inhaler of Albuterol Sulfate 90 mcg. located on the dresser immediately next to the window in room #213, however, there is no current prescription for this medication.
On 4/17/25, at 12:03p.m. resident #6 had two partially used tubes of Systane ointment on the bedside dresser located in resident room #213. However, there is no current prescription for this medication.

Plan of Correction ***Accept*** [redacted] ***05/22/2025)***

On 4/17/25, PCHA removed cream from apartment of Resident #1. The inhaler that was found in the apartment of Resident #6 was removed by PCHA on 4/17/25 as resident stated [redacted] *does not use the inhaler any longer. The order for Resident #6 for Systane ointment was found by RN PC Manager and presented to* [redacted] *prior to the conclusion of the inspection.*

On 5/23/2025, a letter will be mailed to all residents and family members that the Resident Services Office must be contacted to obtain approval and PCP order for any medication that is given to a resident to self-administer. This letter also noted that residents' apartments would be visited by a member of the Resident Services Office to see if any medications exist that do not have an order or that do not have an order to self-administer. These apartment checks will begin the week of 6/1/25 and will contnue monthly for the next 12 months.

Starting 5/21/25, RN PC Manager will review discontinued medication report monthly to removed medications from the carts or apartment which no longer have an active physician order. This will be done monthly indefinately.

Licensee's Proposed Overall Completion Date: *05/20/2025*

183d - Prescription Current *(continued)*

Not Implemented [redacted] - 10/20/2025)

187d - Follow Prescriber's Orders

23. Requirements

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

Description of Violation

Resident #4 is prescribed numerous medications to be given in the morning. On 3/29/25 at the morning medication pass, resident #4 did not receive these prescribed medications, because [redacted] received the medications prescribed to resident #5.
Calcium Carbonate Antacid Chewable 500mg, 1 daily for Supplement.
Flaxseed Oil Capsule 1200mg, 1 daily for Supplement.
Fluoxetine HCl 20mg, 1 daily for Anxiety.
Glucotrol XL Extended Release, 1 daily for Type 2 Diabetes.
Lactobacillus, 1 daily for Urinary Tract Infection.
Ocuvite-Lutein Multivitamin, 1 daily for Supplement.
Vitamin B Complex, 1 daily for Age Related Osteoporosis.
Vitamin D3 1000, 2 daily for Supplement.
Metformin HCl 500mg, 1 twice daily for Type 2 Diabetes.
Motrin IB 200mg, 1 twice daily for Age Related Osteoporosis.
Tylenol Extra Strength 500mg, 1 twice daily for Other Symptoms Involving Musculoskeletal System.

Repeat Violation: 4/16/24 et al.

Plan of Correction ***Accept [redacted] - 05/22/2025)***

Glucose oral gel for Resident # 1 was delivered to the facility in the evening of 4/17/25. All medications for Resident #6 were ordered by Med Tech on 4/17/25 and medications were received on 4/18/25.

Beginning 6/1/25, 4 medication cart audits will be completed each week by RN PC Nurse Manager and PCHA for 4 weeks. Then, monthly cart audits will be conducted by RN PC Nurse Manager and PCHA for the next 12 months.

187d - Follow Prescriber's Orders (continued)

Beginning 6/1/2025, 5 weekly random medication administration observations of LPNs and Med Techs will be conducted RN PC Nurse Manager. This will continue for 3 months. Then. 5 biweekly medication administration observations will be conducted by RN PC Nurse Manager for 3 months. Then 5 monthly random medication administration observations will be conducted by RN PC Nurse Manager for 3 months.

Licensee's Proposed Overall Completion Date: *05/20/2025*

Implemented ([redacted] - 10/20/2025)