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

March 31, 2026

[redacted]
MILLCREEK MANOR
[redacted]

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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/29/2025, 01/14/2026 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: *LECOM PARKSIDE AT GLENWOOD* **License #**: *45384* **License Expiration**: *08/04/2026*

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

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

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *MILLCREEK MANOR*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *09/19/2002* **Issued By**: *Dept. of Labor & Industry*

Staffing Hours

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

Inspection Information

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

Reason: *Complaint* **Exit Conference Date**: *01/14/2026*

Inspection Dates and Department Representative

12/29/2025 - On-Site: [redacted]

01/14/2026 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *144* **Residents Served**: *70*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd Floor* **Capacity**: *16* **Residents Served**: *12*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *12* **Are 60 Years of Age or Older**: *70*

Diagnosed with Mental Illness: *7* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *2*

Inspections / Reviews

12/29/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *02/15/2026*

03/03/2026 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/24/2026*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/30/2026*

Inspections / Reviews *(continued)*

03/31/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/24/2026*

Reviewer: [redacted] **Follow Up Type:** *Not Required*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Resident [redacted] assessment and support plan, dated [redacted], indicates the resident is non-verbal, has a history of repeated falls, requires total physical assistance with transferring in/out of bed/chair, ambulating, turning and positioning in bed/chair, and requires extensive, regular supervision in the home and cannot leave unattended due to [redacted] diagnosis of early onset [redacted] and mobility needs. To meet these needs, staff or [redacted] personal companion will assist [redacted] with all transfers and reposition [redacted] every 2 hours, using pillows to offload pressure as needed, as [redacted] sits in [redacted] recliner after meals and in the evening. Staff interviews indicate they are to put the footrests up when they assist resident [redacted] in [redacted] recliner.

On [redacted] at approximately 6:30p.m., staff person A and staff person B assisted resident [redacted] and positioned [redacted] on [redacted] recliner; however, they failed to put the footrests up. A short time later, resident [redacted] alerted staff person A and staff person B that resident [redacted] had fallen. Staff person A went to resident [redacted] bedroom and found [redacted] lying on the floor, bleeding from [redacted] lip. Staff person A placed a pillow under resident [redacted]s head, left the bedroom, and closed the door.

At approximately 7:15p.m., staff person A reported resident [redacted]s fall to staff person C. Staff person C called 911. Staff person D went to resident [redacted]s bedroom and found the door closed. When staff person D opened the door, [redacted] found resident [redacted] alone, lying on the floor, bleeding from [redacted] lip, with the lights off. Staff person D immediately notified staff person E, LPN. Staff person C and staff person E assessed resident [redacted] and staff stayed with the resident until the ambulance arrived. Resident [redacted] sustained a cut to [redacted] nose and a bloody lip. EMS assessed resident [redacted] and determined [redacted] did not need to go to the hospital. However, this incident was not reported to the local Area Agency on Aging until [redacted] at 3:00p.m.

Plan of Correction ***Accept [redacted] - 03/03/2026)***

On 2/12/26, the Administrator trained the DON and the ADON of the regulation and responsibility to report any allegations of abuse to the Area Agency on Aging within 24 hours. All staff will be trained on their responsibility of reporting any alleged abuse to a supervisor immediately at the staff meeting on March 5, 2026. Beginning 2/16/26, for the next four weeks the administrator will randomly ask 5 staff how would they respond to if they see an alleged abuse situation.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented [redacted] - 03/31/2026)

16c - Written Incident Report

2. 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

Resident [redacted] assessment and support plan, dated [redacted], indicates the resident is non-verbal, has a history of

16c Written Incident Report (continued)

repeated falls, requires total physical assistance with transferring in/out of bed/chair, ambulating, turning and positioning in bed/chair, and requires extensive, regular supervision in the home and cannot leave unattended due to [redacted] diagnosis of [redacted] and mobility needs. To meet these needs, staff or [redacted] personal companion will assist [redacted] with all transfers and reposition [redacted] every 2 hours, using pillows to offload pressure as needed, as [redacted] sits in [redacted] recliner after meals and in the evening. Staff interviews indicate they are to put the footrests up when they assist resident [redacted] in [redacted] recliner.

On [redacted] at approximately 6:30p.m., staff person A and staff person B assisted resident [redacted] and positioned [redacted] on [redacted] recliner; however, they failed to put the footrests up. A short time later, resident [redacted] alerted staff person A and staff person B that resident [redacted] had fallen. Staff person A went to resident [redacted]s bedroom and found [redacted] lying on the floor, bleeding from [redacted] lip. Staff person A placed a pillow under resident [redacted]s head, left the bedroom, and closed the door.

At approximately 7:15p.m., staff person A reported resident [redacted]s fall to staff person C. Staff person C called 911. Staff person D went to resident [redacted]s bedroom and found the door closed. When staff person D opened the door, [redacted] found resident [redacted] alone, lying on the floor, bleeding from [redacted] lip, with the lights off. Staff person D immediately notified staff person E, LPN. Staff person C and staff person E assessed resident [redacted] and staff stayed with the resident until the ambulance arrived. Resident [redacted] sustained a cut to [redacted] nose and a bloody lip. EMS assessed resident [redacted] and determined [redacted] did not need to go to the hospital. However, this incident was not reported to the Department in a manner designated by the Department.

Plan of Correction ***Accept [redacted] - 03/03/2026)***

On 2/12/26, the Administrator trained the DON and the ADON of the regulation and responsibility to report any allegations of abuse to the Department of Human Services within 24 hours. All staff will be trained on be trained on their responsibility of reporting any alleged abuse to a supervisor immediately at the staff meeting on March 5, 2026. Beginning 2/16/26, for the next four weeks the administrator will randomly ask 5 staff how would they respond to if they see an alleged abuse situation.

Licensee's Proposed Overall Completion Date: *03/27/2026*

Implemented [redacted] - 03/31/2026)

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

Resident [redacted]s assessment and support plan, dated [redacted] indicates the resident is non verbal, has a history of repeated falls, requires total physical assistance with transferring in/out of bed/chair, ambulating, turning and positioning in bed/chair, and requires extensive, regular supervision in the home and cannot leave unattended due to [redacted] diagnosis of [redacted] and mobility needs. To meet these needs, staff or [redacted] personal companion will assist [redacted] with all transfers and reposition [redacted] every 2 hours, using pillows to offload pressure as needed, as [redacted] sits in [redacted] recliner after meals and in the evening. Staff interviews indicate they are to put the footrests up when they assist resident [redacted] in [redacted] recliner.

On [redacted] at approximately 6:30p.m., staff person A and staff person B assisted resident [redacted] and positioned [redacted] on

42b Abuse (continued)

[redacted] recliner; however, they failed to put the footrests up. A short time later, resident [redacted] alerted staff person A and staff person B that resident [redacted] had fallen. Staff person A went to resident [redacted] bedroom and found [redacted] lying on the floor, bleeding from [redacted] lip. Staff person A placed a pillow under resident [redacted] head, left the bedroom, and closed the door.

At approximately 7:15p.m., staff person A reported resident [redacted] fall to staff person C. Staff person C called 911. Staff person D went to resident [redacted]s bedroom and found the door closed. When staff person D opened the door, [redacted] found resident [redacted] alone, lying on the floor, bleeding from [redacted] lip, with the lights off. Staff person D immediately notified staff person E, LPN. Staff person C and staff person E assessed resident [redacted] and staff stayed with the resident until the ambulance arrived. Resident [redacted] sustained a cut to [redacted] nose and a bloody lip. EMS assessed resident [redacted] and determined [redacted] did not need to go to the hospital.

Plan of Correction ***Accept [redacted] - 03/03/2026)***

Resident [redacted] care plan was updated to include ensuring that both foot rests are up when [redacted] is in [redacted] recliner. All staff were trained on their responsibility to ensure all safety measures are followed for each resident at the staff meeting on March 5, 2026. Beginning 2/16/26, for the next 4 weeks, the DON, ADON, Administrator and Recreational Director will do random visits to 2 resident rooms/week to verify that all safety measures are in place for the resident, if they are not, the staff will be immediately retrained and safety measure put in place. Reports will be submitted to the Administrator.

Licensee's Proposed Overall Completion Date: 03/27/2026

Implemented ([redacted] - 03/31/2026)

234b - Support Plan Needs Elements

4. Requirements

2600.
234.b. The support plan must identify the resident's physical, medical, social, cognitive and safety needs.

Description of Violation

The support plan, dated [redacted] for resident [redacted] did not address the use of bed bolsters, why they are being used, how often they are to be used and who is responsible for checking on them.

The support plan, dated [redacted] for resident [redacted] did not address the use of a lap belt, why it is being used, how often it is to be used and who is responsible for checking on this.

The support plan dated [redacted] for resident [redacted] does not address that resident [redacted] apartment door should be open at all times when resident is in the room without staff.

Plan of Correction ***Accept ([redacted] - 03/03/2026)***

Resident [redacted] care plan was updated to include all supports need and time frames for checking the supports. Staff will be trained on these supports by the DON or ADON by March 1, 2026. Beginning 2/16/26, the DON and the ADON will do 3 audit checks of care plans each week for 4 weeks to ensure all safety needs are met

Licensee's Proposed Overall Completion Date: 03/13/2026

Implemented ([redacted] - 03/31/2026)