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

January 11, 2024

[redacted]
ERIE OPS LLC
[redacted]

RE: WESTLAKE WOODS AL
3302 WEST LAKE ROAD
ERIE, PA, 16505
LICENSE/COC#: 45407

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/28/2023 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: *WESTLAKE WOODS AL* **License #**: *45407* **License Expiration**: *10/31/2024*

Address: *3302 WEST LAKE ROAD, ERIE, PA 16505*

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

Administrator

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

Legal Entity

Name: *ERIE OPS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/31/1997* **Issued By**: *Dept. of Labor*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *71* **Waking Staff**: *53*

Inspection Information

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

Reason: *Complaint, Indicator* **Exit Conference Date**: *09/28/2023*

Inspection Dates and Department Representative

09/28/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *79* **Residents Served**: *48*

Special Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: [redacted]

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *48*

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

Have Mobility Need: *23* **Have Physical Disability**: [redacted]

Inspections / Reviews

09/28/2023 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/23/2023*

Inspections / Reviews *(continued)*

11/06/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/13/2023*

11/14/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/15/2023*

01/11/2024 - Document Submission

Submitted By: [redacted] **Date Submitted:** *01/11/2024*

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

16c Incident reporting

1. Requirements

2800.
16.c. The residence shall report the incident or condition to the Department's assisted living residence office or the assisted living residence complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2800.15 (relating to abuse reporting covered by law).

Description of Violation

Resident [redacted] is prescribed [redacted] take one [redacted] orally every eight hours as needed for moderate pain. However, on 9/8/23, Resident [redacted] was administered the medication ordered for resident [redacted], by staff member A. The error was discovered by staff member A, during the controlled medication count performed at the end of that same shift on 9/8/23, however, this incident was not reported to the department.

Plan of Correction ***Accept[redacted] - 11/14/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

While the Licensing Representatives were on site, 9/28/2023, the Executive Director completed and submitted incident report. It was submitted via email to Department the same day.

The Executive Director was informed at time of incident verbally. The Executive Director failed to remember to report the incident. The Executive Director or designee will implement tools for the staff to notify verbally and to follow up in written format for reportable incident or condition. Training on regulation 2800.16 and the tools will be completed no later than 11/30/2023.

Starting the week of 11/13/2023, the Executive Director or designee will monitor the use of the tools weekly for four weeks following completion of training and implementation of the tools. Additional weekly audits will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Executive Director or designee will monitor monthly until six consecutive months of compliance is demonstrated.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented[redacted] - 01/11/2024)

23a ADL assistance

2. Requirements

2800.
23.a. A residence shall provide each resident with assistance with ADLs as indicated in the resident's assessment and support plan.

Description of Violation

Resident [redacted], assessment and support plan, dated [redacted], indicates the resident requires assistance with showering

23a ADL assistance (continued)

on Tuesdays and Saturdays from [redacted] to [redacted] However, resident [redacted], has received only one shower in approximately the past 3 weeks.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

In discussion with resident [redacted], [redacted] legal representative, and team members, it was confirmed that the resident had received shower(s) since [redacted] that were not reported to Licensing Representative when on site. Resident [redacted] was offered a shower by Care Team Manager on [redacted]. Resident [redacted] declined a shower and stated [redacted] only wanted showered once a week on Saturday evenings. [redacted] wanted to wait until Saturday, [redacted], for [redacted] next scheduled shower because [redacted] feels better sticking with a routine. Resident [redacted] was showered on [redacted] by a Direct Care Staff member.

The Care Team Manager compared service plans to the shower schedule. Updates were made as needed for residents, days, and shifts. This was completed by the Care Team Manager on [redacted].

The Care Team Manager or designee will conduct training on how to document the completion or refusal of a shower on the Weekly Shower Schedule. The training will be completed by [redacted]. The Care Team Manager or designee will train new staff on the shower schedule as part of onboarding.

Starting the week of 11/13/2023, the Care Team Manager or designee will monitor the shower schedule up to three times a week to measure compliance. Additional weekly audits will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Care Team Manager or designee will monitor monthly until six months of consecutive compliance is demonstrated.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented [redacted] - 01/11/2024)

60b - Additional Staffing

3. Requirements

2800.
60.b. The Department may require additional staffing as necessary to protect the health, safety and well-being of the residents. Requirements for additional staffing will be based on the resident's assessment and support plan, the design and construction of the home and the operation and management of the home.

Description of Violation

On 8/21/23, and 8/22/23, there were 48 residents residing in the home. Of the 48, residents residing in the home 23,

60b - Additional Staffing (continued)

of those residents had some form of mobility need. Of the 23 residents with mobility needs resident #s [redacted], and [redacted] required a two person assist services. Resident #s [redacted] and [redacted] required Hoyer lift services. Resident #s [redacted] and [redacted], are unable to self-propel their wheelchairs. Multiple, staff members indicate that it takes approximately 5 minutes to transfer a resident requiring Hoyer lift services from their bed to their wheelchair. The home's structural design is of two-story construction that has one elevator. Resident #s [redacted] and [redacted] reside on the home's first story floor. Resident #s [redacted], and [redacted] reside on the home's second story floor. On 8/30/22, a fire safety expert determined that the home had 18 minutes and 0 seconds to evacuate all residents to the outside of the home. However, on multiple dates to include 8/21/23, and 8/22/23, only three staff members were present from 10:45 p.m., through 6:00 a.m. On 8/21/23, staff members B, C, and D, were the only staff members on duty from 10:45 p.m., through 6:00 a.m. On 8/23/23, staff members B, D, and E, were the only staff members on duty from 10:45 p.m., through 6:00 a.m.

Plan of Correction ***Accept [redacted] - 11/06/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The Residence acknowledges the need for and importance of having adequate staff available to care for and assist residents in the event of an emergency.
The Environmental Services Manager supervised a third shift fire drill with three staff members on May 24, 2023. The drill was completed with residents being evacuated to the fire safe area within the time determined by the Fire Safety Expert.

The Executive Director or designee will review the assessment and support plans for care needs to include but not limited to the number of residents, immobile residents, two person assists, and any changes to resident needs at least weekly. As is the process, adjustments to staffing levels are made based on the needs of the residents as specified in the resident's assessment and support plan. Staffing levels are reviewed to evaluate that sufficient staff are scheduled to provide the assisted living services in compliance with applicable regulations and are adjusted accordingly based on the ongoing weekly reviews conducted by the Executive Director or designee. The weekly review will begin the week of 10/30/2023.

Fire Safety Expert will be conducting an overnight fire drill in the month of November. Date to be determined. Staffing for 3rd shift will be readjusted or maintained based on this drill.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented [redacted] - 01/11/2024)

185a Storage procedures

4. Requirements

185a Storage procedures *(continued)*

2800.

185.a. The residence 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 [redacted] is prescribed [redacted] Suppository insert one suppository rectally daily as needed for constipation. However, the medication was not available in the home.

Resident [redacted] is prescribed [redacted] tablet take one tablet sublingually every four hours as needed for cramping. However, the medication is not available in the home.

On 9/24/23, the administration of multiple medications were not documented on resident [redacted] September 2023 medication administration record to include.
Resident [redacted] is prescribed [redacted] tablet take one tablet orally at bedtime. The resident was administered the medication on 9/24/23, however, the medication's administration was not documented in the corresponding field of the resident's September 2023, medication administration record.
Resident#[redacted] is prescribed [redacted] take one tablet orally at bedtime. The medication was administered on 9/24/23, however, the medication's administration was not documented in the corresponding field of the resident's September 2023, medication administration record.

Resident #[redacted] is prescribed [redacted] take one tablet orally every 12 hours. The resident was administered this medication on 9/2/23. however, the medication's administration was not documented in the corresponding field of the resident's September 2023, medication administration record.

Resident [redacted] is prescribed [redacted] take two tablets orally at bedtime for anxiety. The resident was not administered the medication at on 6/29/23, 7/3/23, 7/7/23. However, the resident's June and July 2023 medication administration record indicates that the medication was administered on 6/29/23, 7/3/23, and 7/7/23.

Resident #[redacted] is prescribed [redacted] units subcutaneously before meals if [redacted] is less then [redacted] call MD [redacted] hold sliding scale [redacted] if resident does not eat [redacted] meal. On 9/26/2023 at 4:10 PM the residence [redacted] indicated a [redacted] level of [redacted] calling for [redacted]. The [redacted] units of [redacted] were administered; however, the medication's administration was not documented in the corresponding field of the resident's September 2023, medication administration record.

On 9/2/23, resident [redacted]'s medication administration record failed to document multiple medication administrations to include, Resident #[redacted] is prescribed [redacted] take [redacted] tablet orally twice daily. The resident was administered this medication on 9/2/2023, however, the medication's administration was not documented in the corresponding field of the resident's September 2023, medication administration record.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any

185a Storage procedures (continued)

proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

The Executive Director reordered medication for delivery for Resident [redacted] Resident [redacted], Resident [redacted], and Resident [redacted] while Licensing Representatives were on site, 9/28/2023. The Executive Director confirmed delivery of medications.

The Executive Director and designees completed medication cart audits during the week of 10/2/23 to verify that prescribed medications/treatments were available for administration. Medications were reordered and delivered if needed.
The Health and Wellness Director or designee will complete weekly cart audits. Additional weekly cart audits will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.
Team members who administer medications will be provided refresher training on medication reordering process for residents that use preferred pharmacy and outside pharmacies. The training will be held by 11/30/23 by the Health and Wellness Director or designee.

The Licensing Representative and Executive Director confirmed administration with medication staff on 9/28/23. The Executive Director completed manual entries in the eMAR system for the omitted documentation.

Team members who administer medications were provided refresher training on medication administration steps including documentation upon completion of administration. The training was held on 10/26/23 by a sister Community Health and Wellness Director.

The Health and Wellness Director or designee will monitor the electronic medication administration record three times weekly to verify documentation of services on the medication administration record for the residents receiving the service. The Health and Wellness Director or designee will continue weekly monitoring of the electronic medication administration records (eMAR). Additional weekly monitoring of eMAR will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.

The Executive Director confirmed that the medication was not administrated consistent with incident report submitted to the BHSL on 7/21/23. The Executive Director completed manual entries in the eMAR system to reflect that the medication was not administered on 10/20/23.

Team members who administer medications were provided refresher training on medication administration steps including how to document a medication that is not administered. The training was held on 10/26/23 by a sister Community Health and Wellness Director.

Starting the week of 11/13/2023, the Health and Wellness Director or designee will monitor the electronic medication administration record three times weekly to verify documentation of services on the medication administration record for the residents receiving the service. The Health and Wellness Director or designee will

185a Storage procedures (continued)

continue weekly monitoring of the electronic medication administration records (eMAR). Additional weekly monitoring of eMAR will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented [redacted] - 01/11/2024)

187d Follow prescriber's orders

5. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed tramadol take one tablet [redacted] orally every eight hours as needed for moderate pain. However, on 9/8/23, the medication ordered for resident [redacted] was administered to resident [redacted]

Resident [redacted] is prescribed [redacted] tabs take [redacted] tablet orally daily; however, the resident was not administered the medication from 9/13/23, through 9/19/23, The medication was not available in the home.

Resident [redacted] is prescribed [redacted] take [redacted] tablet orally at bedtime. However, the resident was not administered the medication on 9/26/23, and 9/27/23. The medication was not available in the home.

Resident [redacted] is prescribed [redacted] take [redacted] tablets orally at bedtime for anxiety. However, the resident was not administered the medication on 6/29/23, 7/3/23, and 7/7/23.

Resident [redacted] is prescribed [redacted] tab take [redacted] tablet orally daily; however, the medication was not administered on 9/18/2023. The medication was not available in the home.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Team members who administer medications were provided refresher training on medication administration steps including the 6 rights of medication administration which includes following the directions of the provider. The training was held on 10/26/23 by a sister Community Health and Wellness Director.

The Health and Wellness Director or designee will review 10% of resident electronic medication administration record to confirm that the home is following the directions of the prescriber. The Health and Wellness Director or

187d Follow prescriber's orders (continued)

designee will continue weekly monitoring of the electronic medication administration records (eMAR). Additional weekly monitoring of eMAR will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.

The Executive Director reordered medication for delivery for Resident [redacted], Resident [redacted], Resident [redacted] while Licensing Representatives were on site, 9/28/2023. The Executive Director confirmed delivery of medications.
The Executive Director and designees completed medication cart audits during the week of 10/2/23 to verify that prescribed medications/treatments were available for administration. Medications were reordered and delivered if needed. The Health and Wellness Director or designee will continue weekly cart audits. Additional weekly cart audits will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.

Team members who administer medications will be provided refresher training on medication reordering process for residents that use preferred pharmacy and outside pharmacies. The training will be held by 11/30/23 by the Health and Wellness Director or designee.

The Executive Director confirmed that the medication was not administrated consistent with incident report submitted to the BHSL on 7/21/23. The Executive Director completed manual entries in the eMAR system to reflect that the medication was not administered on 10/20/23.

Team members who administer medications were provided refresher training on medication administration steps including how to document a medication that is not administered. The training was held on 10/26/23 by a sister Community Health and Wellness Director.

Starting the week of 11/13/2023, the Health and Wellness Director or designee will monitor the electronic medication administration record three times weekly to verify documentation of services on the medication administration record for the residents receiving the service. The Health and Wellness Director or designee will continue weekly monitoring of the electronic medication administration records (eMAR). Additional weekly monitoring of eMAR will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Health and Wellness Director or designee will monitor monthly until six months of consecutive compliance is demonstrated.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented [redacted] - 01/11/2024)

188b Medication error reporting

6. Requirements

2800.
188.b. A medication error shall be immediately reported to the resident, the resident's designated person and the prescriber.

188b Medication error reporting *(continued)*

Description of Violation

Resident [redacted] is prescribed [redacted] take [redacted] orally every eight hours as needed for moderate pain. On 9/8/23, the medication ordered for resident [redacted] was administered to resident [redacted]. However, the medication error was not reported to resident [redacted]'s designated person or their prescribing physician.

Plan of Correction ***Accept [redacted] - 11/14/2023)***

This plan of correction is submitted as required under State law. The submission of this Plan of Correction does not constitute any admission of civil or criminal liability on the part of the named Community as to contents stated in this Statement of Deficiencies. Any changes to the Community's policies and procedures made because of its receipt of this Statement of Deficiencies are subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

While the Licensing Representatives were on site, 9/28/2023, the Executive Director notified the resident, resident's designated party and the prescriber.
The Executive Director was informed at time of incident verbally. The Executive Director failed to report by omission [redacted] forgot). The Executive Director or designee will implement tools for the staff to notify verbally and to follow up in written format reporting of a medication error. Training on regulation 2800.188.b and the tools will be completed no later than 11/14/2023.

Starting the week of 11/13/2023, the Health and Wellness Director or designee will ensure that all designated parties are notified as soon as practicable within the 24 hours window of a medication error. The Executive Director or designee will monitor weekly for four weeks following completion of training and implementation of the tools. Additional weekly audits will be conducted until there are four weeks of consecutive compliance with this regulation. Once four weeks of consecutive compliance is achieved the Executive Director or designee will monitor monthly until six consecutive months of compliance is demonstrated.

Licensee's Proposed Overall Completion Date: *11/30/2023*

Implemented [redacted] - 01/11/2024)