STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395404	A. BLDG: __--_____ B. WING: _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
LECOM AT PRESQUE ISLE, INC. STATE LICENSE NUMBER: **530402**	**4114 SCHAPER AVENUE ERIE, PA 16508**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 16, 2025, at Lecom at Presque Isle, Inc., it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

LECOM AT PRESQUE ISLE, INC.

STATE LICENSE NUMBER: 530402

SURVEY EXIT DATE: 01/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #530402 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 16, 2025, it was determined that Lecom at Presque Isle, Inc. was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type II (000), unprotected, non-combustible building, that is fully sprinklered.	K 0000		

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K 0293 SS=B	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	The directional exit signs for the following corridors have been installed: A. Main floor corridor to North Nurse station B. Main floor corridor to the Noth/South corridors C. Main floor employee hall to the main corridor D. Main floor Northwest hall toward the north Nurse station The maintenance director and/or designee will ensure that the facility directional signs will be maintained with continuous illumination.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0293 SS=B	Continued from page 2 Based on observation and interview, the facility failed to maintain exit signs for four of over forty signs. Findings include: Observation on January 16, 2025, between 11:32 a.m. and 12:35 p.m., revealed the following exit sign deficiencies: A. (11:32 a.m.) Main floor corridor from Ambassador to North nurse station had a missing directional exit sign; B. (11:49 a.m.) Main floor entrance corridor to the North/South corridors had a missing directional exit sign; C. (11:53 a.m.) Main floor employee hall to the main corridor had a missing directional exit sign; D. (12:35 p.m.) Main floor Northwest hall towards North nurse station had a missing directional exit sign. Ref: NFPA 101 7.10	K 0293		

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K 0293 SS=B	Continued from page 3 Interview with the maintenance manager on January 16, 2025, at 12:35 p.m., confirmed the exit sign deficiencies existed at the time of the survey.	K 0293		
K 0325 SS=D	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments	K 0325	The main floor wound care room hand dispenser has been moved to a location in accordance with 8.7.3.1. The Maintenance Director and/or designee will audit all hand dispenser to ensure that they are placed in accordance with 8.7.3.1.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0325 SS=D	Continued from page 4 * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 0325		

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K 0325 SS=D	Continued from page 5 Based on observation and interview, the facility failed to maintain alcohol-based hand dispensers in one of five wings. Findings include: Observation on January 16, 2025, at 11:38 a.m., revealed the main floor wound care room had a hand dispenser installed directly over an electrical outlet. Interview with the maintenance manager on January 16, 2025, at 11:38 a.m., confirmed the alcohol-based hand sanitizer deficiency.	K 0325		
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 0345	The semi-annual visual fire alarm inspection has been scheduled. The maintenance director and/or designee will ensure that all visual fire alarm inspections are completed semi-annually. The administrator and/or designee will monitor for compliance.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0345 SS=F	Continued from page 6 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to maintain fire alarm system components, affecting the entire facility. Findings include: Document review on January 16, 2025, at 11:05 a.m., revealed the facility could not provide documentation for the semi-annual visual fire alarm inspection. The last-dated inspection occurred May 30, 2024. Interview with the maintenance manager on January 16, 2025, at 11:05 a.m., confirmed the missing documentation.	K 0345		

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K 0347 SS=F	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by:	K 0347	The sensitivity testing has been scheduled to be completed. The maintenance director and/or designee will ensure that the sensitivity testing is completed and documentation of the test results are obtained.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0347 SS=F	Continued from page 8 Based on document review and interview, the facility failed to maintain regulations for one of one fire alarm systems. Findings include: Document review on January 16, 2025, at 11:10 a.m., revealed the facility lacked documentation that the most recent sensitivity test results were documented. Interview with the maintenance manager on January 16, 2025, at 11:10 a.m., confirmed sensitivity testing documentation was unavailable at the time of the survey.	K 0347		
K 0355 SS=C		K 0355		

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K 0355 SS=C	Continued from page 9 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	The facility received the certification for the fire extinguisher service technician on January 31, 2025. The maintenance director and/or designee will ensure that the certification for the fire extinguisher service technician is received before or at the time of inspection.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0355 SS=C	Continued from page 10 Based on document review and interview, it was determined that the facility failed to provide a current certification for the fire extinguisher service technician, for one of one technician, per NFPA 10-7.1.2. Findings include: Document review on January 16, 2025, at 11:03 a.m., revealed the facility could not produce the certification for the fire extinguisher service technician at the time of the survey. Interview with the maintenance manager on January 16, 2025, at 11:03 a.m., confirmed the inspector's certification was unavailable at the time of the survey.	K 0355		
K 0363 SS=B		K 0363		

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K 0363 SS=B	Continued from page 11 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	Resident room #74 now positively latches. The Maintenance Director and/or designee will complete an audit of all doors to ensure that all doors positively latch. Audits will be completed quarterly for compliance	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0363 SS=B	Continued from page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet corridor door requirements for one of over twenty corridor doors. Findings include: Observation on January 16, 2025, at 11:25 a.m., revealed the resident room #74 door failed to latch in the frame. Interview with the maintenance manager on January 16, 2025, at 11:25 a.m., confirmed the door deficiency.	K 0363		
K 0372 SS=D		K 0372		

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K 0372 SS=D	Continued from page 13 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Smoke barriers are now maintained in the following areas: a. Main floor IT room ceiling tiles have been replaced b. Main floor laundry boiler room ceiling tiles have been replaced. The maintenance director and/or designee will complete an audit to ensure all smoke barriers are maintained.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0372 SS=D	Continued from page 14 Based on observation and interview, the facility failed to maintain smoke barrier requirements in two of over ten rooms. Findings include: Observation on January 16, 2025, between 11:52 a.m. and 11:56 a.m., revealed the facility failed to maintain smoke barriers in the following locations: A. (11:52 a.m.), Main floor IT room had cracked, broken, and missing ceiling tiles; B. (11:56 a.m.), Main floor laundry boiler room had loose, missing, and unsealed ceiling tiles. Interview with the maintenance supervisor on January 16, 2025, at 11:56 a.m. and confirmed the smoke barrier deficiencies.	K 0372		
K 0912 SS=D		K 0912		

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LECOM AT PRESQUE ISLE, INC. STATE LICENSE NUMBER: **530402**	**4114 SCHAPER AVENUE** **ERIE, PA 16508**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0912 SS=D	Continued from page 15 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	Ground fault circuit interrupters (GFCI) have been installed in the following areas: a. Main floor physical therapy room water cooler receptacle b. Main floor south wing nurse station eye wash station receptacle c. Main floor north wing nurse station eye wash station receptacle The maintenance director and/or designee will complete a whole house audit to ensure electrical receptacles are all in compliance.	Completion Date: **03/03/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395404	A. BLDG: 01 B. WING:	01/16/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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K 0912 SS=D	Continued from page 16 Based on observation and interview, the facility failed to maintain electrical receptacles in three of over twenty rooms. Findings include: Observation on January 16, 2025, between 11:48 a.m. and 12:38 p.m., revealed the facility failed to ensure ground fault circuit interrupter (GFCI) protection in the following areas: A. (11:48 a.m.) Main floor physical therapy room water cooler receptacle; B. (12:21 p.m.) Main floor south wing nurse station eye wash station receptacle; C. (12:38 p.m.) Main floor north wing nurse station eye wash station receptacle. Interview with the maintenance manager on January 16, 2025, at 12:38 p.m., confirmed the electrical outlet deficiencies.	K 0912		

Certified End Page

LECOM AT PRESQUE ISLE, INC.

STATE LICENSE NUMBER: 530402

SURVEY EXIT DATE: 01/16/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY