pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: January 13, 2017

Ms. Sharon E. Bryant, Administrator
Saint Mary's Home of Erie
Saint Mary's at Asbury Ridge
4855 West Ridge Road
Erie, Pennsylvania 16506

RE: Saint Mary's at Asbury Ridge
413420

Dear Ms. Bryant:

As a result of the Department of Human Services' licensing inspection on February 17, 2016 and February 18, 2016, of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Sincerely,

Jason Williams
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

PCH Name: SAINT MARY S AT ASBURY RIDGE	License Number: 413420
Address: 4855 WEST RIDGE ROAD, ERIE, PA 16506	County: Erie
Administrator: Sharon Bryant	Region: WEST

Legal Entity Name: SAINT MARY'S HOME OF ERIE

Legal Entity Address: 4855 WEST RIDGE ROAD, ERIE, PA 16506

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NOV 17 2016
WEST REGION FIELD OFFICE
Human Services Licensing

Certificate(s) of Occupancy

C-2 LP
08/22/2001
Labor & Industry

Staffing Hours

Resident Support: 0	Total Daily Staff: 104	Waking Staff: 78
Type of Inspection: Partial	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)

Incident

On-Site Inspections Dates and Department Representatives On-Site

02/17/2016: Cutter, Jan; Whitney, Diane
02/18/2016: Cutter, Jan; Whitney, Diane

Off-Site Inspection Dates and Inspectors, if Applicable

Other Details

Partial or Full Triggers: Random Indicators:

Resident Demographic Data as of Inspection Dates

Licensed Capacity: 164

Number of Residents Served: 76

Secured Dementia Care Unit in Home: Yes

Area: Area "C"

Secured Dementia Unit Capacity, if Applicable: 16

Number of Residents Served in Secured Dementia Care Unit, if applicable: 14

Number of Current Hospice Residents: 1

Number of Hospice Residents in past year: 4

Number of Residents who:

Receive Supplemental Security Income: 0

Are 60 Years of Age or Older: 76

Have Mental Illness: 4

Have an Intellectual Disability: 0

Have a Mobility Need: 28

Have a Physical Disability: 0

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WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 41342 - 02/17/2016 - Cutter, Jan.
PCH Name: SAINT MARY'S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On [redacted]16, at approximately 12:30 p.m., staff person A entered resident #1's bedroom to measure the resident's weight. Resident #1 was standing in front of the screened window by the dresser, looking out. The resident became agitated and rushed to his/her bed, laid on the bed, held onto the headboard and stated "No, no, no, you don't need to get my weight. I don't want to live anymore". At this time, staff person B entered the room to assist with obtaining a weight for resident #1. However, the resident continued to refuse being weighed and both staff persons A and B left the room at approximately 12:40 p.m.

Immediately upon leaving resident #1's bedroom, staff persons A and B notified staff person C, the charge nurse, of resident #1's unusual behavior and emotional outburst. At 1:45 p.m. staff person C went to resident #1's bedroom to assess the resident; however, there was no one in the room. Staff person C enlisted the aid of staff persons A and B in searching the building for resident #1. At 1:55 p.m. a building search was initiated. Staff persons A and B again checked resident #1's third floor bedroom as well as other bedrooms on that floor and the recreation room. At 2:05 p.m., staff persons A and B returned to resident #1's bedroom which was noticeably cold. The window in that room was open approximately 12 inches and the screen had been removed. Staff person B looked out the window and observed resident #1, who was wearing a winter coat, lying in the snow on the ground below. At 2:10 p.m., the resident was pronounced deceased. His/her fingers were blue. The death certificate indicates the cause of death was blunt force trauma and fall.

Resident #1 was admitted on [redacted]16 from a skilled nursing facility, where the resident exhibited increased confusion and refused to eat. Physician's progress notes, dated [redacted]16, from the nursing facility indicate the resident needs "24 hour supervision at this point". The resident's preadmission screening form, dated [redacted]16, indicates the resident has minimal supervision needs. Resident #1's medical evaluation, dated 2/4/16, includes diagnoses of mood affective disorder and dementia without behavioral disturbance.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

We believe the alleged violations to regulation 55 Pa. Code 2600.42(b) to be incorrect for the following reasons:

- When Staff person A entered Resident # 1's room and said "Hi [redacted] I'm [redacted]", Resident # 1 "turned around and walked and layed on the bed". Staff persons A and B both observed Resident #1's refusal to be weighed but at no time did Resident # 1 demonstrate urgency or threat of harming [redacted]self. Resident #1 was reminded that [redacted] daughter requested the weight. There was not a physician order for weight to be checked.

  Neither staff person A or B, both being veteran staff of the organization, felt that Resident #1 was in imminent danger of harming [redacted]self as they left [redacted] room. Resident #1's actions and comments were no consistent with indications that would have led them to believe [redacted] would hurt [redacted]self. Resident # 1's concern seemed to be focused on [redacted] weight being taken. See pages 2a of 2 and 2b of 2 (continued)

Unacceptable portion of plan. JN 12/28/16

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page): Audrey Urban

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Audrey Urban — Date: 11/16/2016

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The above plan of correction is approved as of 1/3/17 (Date)

The above plan of correction was approved by JN (Initials)

Plan of correction implementation status as of 1/3/17 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress JN
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

RECEIVED
NOV 17 2016
WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 41342 - 02/17/2016 - Cutter, Jan
PCH Name: SAINT MARY'S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed. (continued)

- Staff person A had encountered Resident #1's spouse prior to going to the room. The spouse did not indicate that Resident #1 was in need of immediate attention.
- Staff A and B promptly reported the matter to Staff C after they left Resident #1's room. Staff person C shared the comment with Resident #1's daughter who indicated that Resident #1 "would have these fits that [redacted] will calm down and be pleasant later." Staff A and B believed that the situation did not rise to the level of urgency that would require immediate intervention.

Unacceptable portion of plan. A.U. 12/2/16

- During Resident #1's skilled nursing admission, Resident #1 had a weight gain of 8 lbs. Admission weight of [redacted]16 was 104 lbs and discharge weight on [redacted]6 was 112 lbs; thus demonstrating an improvement.
- Resident #1's condition did progress during the skilled nursing stay and discharge plans were to return home with [redacted]. A respite stay in Personal Care was offered as the family preferred not to take [redacted] home at that time.
- Both the Personal Care Medical Evaluation and Pre-admission Screening indicated that Resident # 1 was appropriate for admission to Personal Care and the attending physician ordered a discharge to Personal Care.
- The window in Resident #1's room was open **10 inches** not 12 inches. The attached pictures show the jam lock and the measurement of 10 inches. For clarification, the window noted by Staff A that Resident #1 was standing at (bedroom window) was not the window [redacted] exited from (living area window).
- The Death Certificate indicates the cause of death to be blunt force trauma and fall. Both the Death Certificate and the Coroner's report state the manner of death as suicide.

Although we believe the allegations to be incorrect, in accordance with the regulations, we will provide the following steps as a plan of correction:

- Following the incident, an in-service was provided to all Personal Care Staff. The focus of the education was "Resident Changes and Monitoring". Please refer to attached roster.
- Following the incident, a Suicide Prevention Policy was developed.
- Mandatory training is provided upon orientation of a new employee and then annually on the following topics: Behavioral Management, Depression and Dementia.
- The Personal Care Staff will be further in-serviced by December 15, 2016 regarding Behavioral Management, Depression, Dementia and the Suicide Prevention Policy.

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page): Audrey Urban

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): Audrey Urban — **Date** 11/16/2016

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of ________ (Date)

The above plan of correction was approved by ________ (Initials)

Plan of correction implementation status as of ________ (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

SAINT MARY'S ASBURY

REC DEC 28 2016/02:32D

Violation Report: 41342 - 02/17/2016 - Cutter, Jan
PCH Name: SAINT MARY S AT ASBURY RIDGE

DEC 28 2016
WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.42(b) - A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

2a. DESCRIPTION OF VIOLATION

On 2/15/2016, at approximately 12:30 p.m., staff person A entered resident #1's bedroom to measure the resident's weight. Resident #1 was standing in front of the screened window by the dresser, looking out. The resident became agitated and rushed to his/her bed, laid on the bed, held onto the headboard and stated "No, no, no, you don't need to get my weight. I don't want to live anymore". At this time, staff person B entered the room to assist with obtaining a weight for resident #1. However the resident continued to refuse being weighed and both staff persons A and B left the room at approximately 12:40 p.m.

Immediately upon leaving resident #1's bedroom, staff persons A and B notified staff person C, the charge nurse, of resident #1's unusual behavior and emotional outburst. At 1:45 p.m. staff person C went to resident #1's bedroom to assess the resident; however, there was no one in the room. Staff person C enlisted the aid of staff persons A and B in searching the building for resident #1. At 1:55 p.m. a building search was initiated. Staff persons A and B again checked resident #1's third floor bedroom as well as other bedrooms on that floor and the recreation room. At 2:05 p.m., staff persons A and B returned to resident #1's which was noticeable cold. The window in that room was open approximately 12 inches and the screen had been removed. Staff person B looked out the window and observed resident #1, who was wearing a winter coat, lying in the snow on the ground below. At 2:10 p.m., the resident was pronounced deceased. His/Her fingers were blue. The death certificate indicates the cause of death was blunt force trauma and fall.

Resident #1 was admitted on [redacted]16 from a skilled nursing facility, where the resident exhibited increased confusion and refused to eat. Physician's progress notes, dated 2/1/16 from the nursing facility indicate the resident needs "24 hour supervision at this point". The resident's preadmission screening form, dated [redacted]6, indicates the resident has minimal supervision needs. Resident #1's medical evaluation, dated 2/4/16, includes diagnoses of mood affective disorder and dementia without behavioral disturbance.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Within 30 days of receipt of the plan of correction: All staff persons, including administrative staff, will receive education on suicide prevention from a Department-approved outside source. Documentation of this education shall be kept. AU. 12/28/16

Repeat Violation: No	Date(s) of Previous Violation(s):			

Signature of Legal Entity Representative (Required on EVERY Page): Audrey Urban

Printed Name and Title of Legal Entity Representative (Required on EVERY Page): AUDREY URBAN — Date: 12/28/2016

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The above plan of correction is approved as of ______ (Date)

The above plan of correction was approved by ______ (Initials)

Plan of correction implementation status as of ______ (Date)

- ☐ Fully Implemented
- ☐ Partially Implemented - Adequate Progress
- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented