pennsylvania
DEPARTMENT OF HUMAN SERVICES

NOV 0 1 2016

Sr. Phyllis McCracken, President/CEO
Saint Mary's Home of Erie
4855 West Ridge Road
Erie, Pennsylvania 16506

RE: Saint Mary's at Asbury Ridge
License #: 413420

Dear Sr. McCracken:

As a result of the Department of Human Services' annual licensing inspections on June 7, 2016 and June 8, 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,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

Bureau of Human Services Licensing
625 Forster Street, Room 631 | Harrisburg, PA 17120 | 717.783.3670 | F 717.783.5662 | www.dhs.state.pa.us

VIOLATION REPORT
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

PCH Name: SAINT MARY S AT ASBURY RIDGE	License Number: 41342
Address: 4855 WEST RIDGE ROAD, ERIE, PA 16506	County: Erie
Administrator: Sharon Bryant (resigned); Allen Bonace	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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Certificate(s) of Occupancy
C-2 LP
08/01/2001
L&I

Staffing Hours
Resident Support: 0 | Total Daily Staff: 112 | Waking Staff: 84

Type of Inspection: Full | BHA Docket Number: | Notice: Unannounced

Reason(s) for Inspection(s)
Renewal, Incident

On-Site Inspections Dates and Department Representatives On-Site
06/07/2016: Bedford, Katie; Barry, Courtney; DeLuca, Santo
06/08/2016: Bedford, Katie; Barry, Courtney; DeLuca, Santo

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 who:**
Number of Residents Served: 78	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 78
Area: Left wing	Have Mental Illness: 3
Secured Dementia Unit Capacity, If Applicable: 16	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, if applicable: 14	Have a Mobility Need: 34
Number of Current Hospice Residents: 1	Have a Physical Disability: 0
Number of Hospice Residents in past year: 3	

Sister Phyllis McCracken, President/CEO
09/22/16
Sister Phyllis McCracken

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Violation Report: 41342 - 06/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.85(d) - Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

2a. DESCRIPTION OF VIOLATION
On 6/7/16, there were no lids on four large garbage cans in the main kitchen.

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.

Trash cans with lids have been ordered for the main kitchen prep and cooking areas.

The chefs have been instructed that lids must remain in place.

The Dietary Supervisors will monitor daily. The Food Service Director will report quarterly the results to the Quality Assurance Committee.

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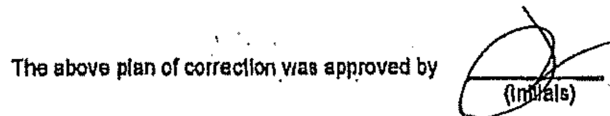
(Required on EVERY Page) Sister Phyllis McCracken

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Sr. Phyllis McCracken, President/CEO — Date 09/22/16



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The above plan of correction is approved as of 9/28/16 (Date)

The above plan of correction was approved by [signature] (Initials)

Plan of correction implementation status as of 9/28/16 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
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Human Services Licensing

Violation Report: 41342 - 06/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.96(a) - The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

2a. DESCRIPTION OF VIOLATION
On 6/7/16, the first aid kit in the 2014 Chrysler Town and Country van did not contain eye coverings.

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.

An eye protector was placed in the transportation van on the day of survey.

Transportation staff were educated by the Director of Support Services regarding maintaining the contents of the kit and replacing items when expired or used. The Activity Department staff were educated by the Facility Administrator.

A check list for contents of the required first aid kit has been developed and is checked every time the vans are used.

Maintenance Team leader will monitor the completion of the check list and will report quarterly the results to the Quality Assurance Committee.

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Date 09/22/16

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Violation Report: 41342 - 06/07/2016 - Bedford, Katie PCH Name: SAINT MARY S AT ASBURY RIDGE	WEST REGION FIELD OFFICE Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.102(l) - A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a seperate bar clearly labeled for each resident who shares a bathroom.

2a. DESCRIPTION OF VIOLATION

On 6/7/16, there was a used bar of soap on top of the soap dispenser in the common bathroom near the nurses' station in the secured dementia care unit (SDCU).

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The bar of soap was immediately removed from the common bathroom located in the Alzheimer's Unit.

The employees were re-educated during the June 22- 29, 2016 employee meetings regarding residents' personal hygiene items not being left in a common bathroom area.

The Alzheimer's resident's personal bar of soap will be placed in the resident's locked bathroom drawer when not being used. The resident and family members will be informed to use the wall mounted liquid soap in their bathroom rather than placing a bar of soap by the bathroom sink which leads to the Alzheimer's resident relocating their bar of soap to other areas.

The housekeeping staff will check the common bathroom areas in the Alzheimer's Unit daily. The Housekeeping Team Leader will report quarterly the results to the Quality Assurance Committee.

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PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.105(g)(1) - To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use.

2a. DESCRIPTION OF VIOLATION
On 6/7/16, there was an accumulation of lint approximately 1/4" thick in the lint trap of the dryer in the laundry room in the SDCU.

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.

The lint was removed from the dryer the day of survey.

The employees were re-educated during the June 22- 29, 2016 employee meetings regarding removing lint from dryer screens following each use.

A sign stating "remove lint after each use" was placed on the door of the dryer.

The Alzheimer's housekeeper will check the lint screen of the dryer daily.
The Housekeeping Team Leader will report quarterly the results to the Quality Assurance Committee.

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1. REGULATION 55 Pa.Code §2600
2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

2a. DESCRIPTION OF VIOLATION
On 6/7/16, the emergency exit door near room 1138 in the SDCU was very difficult to open, requiring excessive effort to push open.

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.

The emergency exit door was adjusted on the day of survey.

The emergency doors are checked monthly during the Fire Preventative Maintenance Plan.

The maintenance staff was educated by the Director of Support Services regarding proper checking of exit doors.

The maintenance staff will check emergency doors monthly during the Fire Preventative Maintenance. The Maintenance Team Leader will report quarterly the results to the Quality Assurance Committee.

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WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 41342 - 08/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
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.

2a. DESCRIPTION OF VIOLATION
The fire drill record for the drills conducted on 10/20/15 at 1:35, and 5/28/16 at 9:00 does not indicate if they were held in the a.m. or p.m.

The fire drill record does not include the exit routes used during the drills conducted on 6/17/15 at 11:20 p.m., 3/18/16 at 12:15 a.m., 2/28/16 at 6:30 p.m. and 5/26/16 at 9:00.

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.

The Maintenance staff have been re-educated by the Director of Support Services to document a.m. or p.m. following the time of the drill even though the time is logged under a shift column indicating days, evenings and nights.

The Maintenance staff have been re-educated by the Director of Support Services to document the exit route when necessary and to document Not Applicable (NA) when the fire occurs in an area that does not require evacuation to an alternate fire safe zone.

The Maintenance Team Leader will check the fire logs monthly and report quarterly the results to the Quality Assurance Committee.

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Violation Report: 41342 - 08/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.132(d) - Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert.

2a. DESCRIPTION OF VIOLATION
According to the fire drill record, during the fire drill conducted on 3/18/16 at 12:15 a.m., there were 78 residents present in the home; however only 72 evacuated to a fire safe area.

According to the fire drill record, during the fire drill conducted on 5/26/16 at 9:00, there were 82 residents present in the home; however only 60 residents evacuated to a fire safe area.

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.

The monthly fire drill log sheet has been updated to reflect the number of personal care residents present and evacuated from their rooms and common areas on the campus.

The Director of Support Services has re-educated the maintenance staff, who conduct the fire drills, to review the fire drill sheets immediately following the drill for proper completion of each sheet in order that the fire log will be completed accurately.

The Maintenance Team Leader will monitor the fire logs for completion monthly and report quarterly the results to the Quality Assurance Committee.

Immediately - The administrator will ensure that all residents present during a fire drill are evacuated to a fire safe area.

[initials] 9/28/16

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WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report: 41342 - 08/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.141(b)(1) - A resident shall have a medical evaluation at least annually.

2a. DESCRIPTION OF VIOLATION
The most recent medical evaluation for resident #1 was completed on 4/7/15.

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.

Resident #1 medical evaluation was completed by their attending physician.

All personal care residents' medical evaluations were checked for timeliness and found to be current by July 12, 2016 and reported to the Quality Assurance Committee.

The Director of Personal Care has developed a different tracking tool for monitoring the completion of the annual medical evaluations for each personal care resident.
The Director of Personal Care will monitor the log monthly for compliance and report quarterly the results to the Quality Assurance Committee.

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Violation Report: 41342 - 06/07/2016 - Bedford, Katie
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home

2a. DESCRIPTION OF VIOLATION
Resident #2 was prescribed Bupropion tab 75mg, ½ tablet by mouth every morning. The medication was discontinued on 3/16/16; however the medication was still in the medication cart on 6/6/16.

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.

The resident's discontinued medication was removed from the medication cart on the day of survey.

The medication carts were checked to ensure that only current prescriptions were present.

The Director of Personal Care in-serviced the professional nursing staff regarding having only current prescriptions in the medication cart and reviewed the process of removing medications upon discontinuation of an order.

The Director of Personal Care has developed a tool to ensure that discontinued medications are removed from the cart.

Monthly audits of all medication carts for discontinued and expired medications will be performed by assigned professional nursing staff.
The Director of Personal Care will monitor weekly and report quarterly the results to the Quality Assurance Committee.

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PCH Name: SAINT MARY S AT ASBURY RIDGE

WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.187(b) - The information in § 2600.187(a)(13) and § 2600.187(a)(14) shall be recorded at the time the medication is administered.

2a. DESCRIPTION OF VIOLATION
On 5/16/16 and 5/17/16 at bedtime, resident #4 was administered Prednisone 10mg, 2 tablets; however the the staff person(s) who administered the medication on those dates did not initial or record the date and time of administration on the medication administration record.

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.

The nurse who administered the medication to resident #4 was counseled by the Director of Personal Care.

The medication administration process is now computerized. At the end of each shift a report is generated to ensure the documentation of medication has been completed.

The registered nurses and practical nurses will be re-educated regarding the medication administration policy.

The Director of Personal Care has developed a tool to monitor administration documentation. The Director will run weekly audits of missed transactions, investigate and educate or counsel individual nurses as necessary.
The Director of Personal Care will monitor weekly and report quarterly the results to the Quality Assurance Committee.

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Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Sr. Phyllis McCracken, President/CEO — **Date** 09/22/16

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PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600

2600.225(a) - A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

2a. DESCRIPTION OF VIOLATION

The assessment, dated 1/19/16, for resident #4 indicates the resident is independent with toileting and transferring; however, the home's RASP-ADL Flowsheet, dated 1/15/16, indicates the resident needs "supervision on/off toilet."

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.

The RASP-ADL for resident #4 was corrected to match the assessment.

The RASP-ADL of all personal care residents are being checked to ensure that the RASP-ADL matches the assessment. A schedule has been developed by the Director of Personal Care to complete the reviews by October 28, 2016.

The result will be reported to the Quality Assurance Committee by the Director of Personal Care.

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Violation Report: 41342 - 06/07/2016 - Bedford, Katie
PCH Name: SAINT MARY'S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
The medical evaluation for resident #5, dated 11/16/15 does not indicate the resident's the need for the SDCU. Also, it is blank in the areas of mobility needs assessment, height, weight and pulse rate. A second medical evaluation for resident #6, dated 11/16/15, indicates the need for the SDCU, the resident's mobility status assessment and height, weight, and pulse rate; however it was not signed by a physician.

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.

The medical evaluation for resident #5 was completed correctly by the attending physician following the survey.

All medical evaluations were audited and completed as reported to the Quality Committee on July 12, 2016. including the need for an SDCU. 9/20/16

The Director of Personal Care will review the medical evaluation for completion. Incomplete evaluations will be returned to the physician for completion and only the completed medical evaluation will be maintained in the resident's record.

The Director of Personal Care will monitor the completion of the medical evaluation and report quarterly the results to the Quality Assurance Committee.

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PCH Name: SAINT MARY S AT ASBURY RIDGE

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WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.252 - Each resident's record must include the following information: (1) through (26)

2a. DESCRIPTION OF VIOLATION
The most recent photograph in resident #6's record is dated 2/10/14.

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.

Resident #6 picture was taken. All pictures were current as of June 29, 2016.

Residents with outdated pictures were taken and results were reported to the Quality Assurance Committee on July 12, 2016.

The Director of Personal Care has developed a scheduling tool for the completion of the current personal care residents' pictures in a timely manner. The Director has planned to update all photos annually.

The Director of Personal Care will monitor monthly and report quarterly the results to the Quality Assurance Committee.

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

Signature of Legal Entity Representative
(Required on EVERY Page) Sister Phyllis McCracken

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Sr. Phyllis McCracken, President/CEO

Date 09/22/16

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The above plan of correction is approved as of 9/28/16 (Date)

The above plan of correction was approved by [initials] (Initials)

Plan of correction implementation status as of 9/28/16 (Date):

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