pennsylvania
DEPARTMENT OF HUMAN SERVICES

DEC 1 4 2017

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
Certificate #: 413420

Dear Sr. McCracken:

As a result of the Department of Human Services' annual licensing inspection on June 29, 2017 and June 30, 2017, 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Jacqueline L. Rowe
Director

Enclosure
License Inspection Summary

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: SHANA DEBOE	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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Human Services Licensing

Certificate(s) of Occupancy

C-2 LP
09/10/2001
Labor & Industry

Staffing Hours

Resident Support: 0 | Total Daily Staff: 94 | Waking Staff: 71

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

Reason(s) for Inspection(s)

Renewal

On-Site Inspections Dates and Department Representatives On-Site

06/29/2017: Flinner-Alman, Lisa; Evegos, Joseph
06/30/2017: Flinner-Alman, Lisa; Evegos, Joseph

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: 61

Secured Dementia Care Unit in Home: Yes

Area: Left Wing

Secured Dementia Unit Capacity, If Applicable: 16

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

Number of Current Hospice Residents: 0

Number of Hospice Residents in past year: 5

Number of Residents who:

- Receive Supplemental Security Income: 0
- Are 60 Years of Age or Older: 61
- Have Mental Illness: 2
- Have an Intellectual Disability: 0
- Have a Mobility Need: 33
- Have a Physical Disability: 0

Sister Phyllis McCracken 9/25/17

Violation Report: 41342 - 06/29/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

SEP 25 2017
WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.81(b) - Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

2a. DESCRIPTION OF VIOLATION

On 6/30/17, the vinyl was cracked on the left armrest, approximately 3 1/2" by 1/4", on resident #1's wheelchair, posing a skin tear hazard.

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 representative has agreed to the alterations which are being made to this resident's wheelchair including new armrests.

Staff have been educated to monitor resident equipment weekly with the resident's bath and to report any potential hazards to their nurse immediately.

A whole-house audit of all wheelchairs, walkers, prosthetic devices and other equipment items used by our residents will be completed by 10/20/2017 to ensure that the devices are clean and free of cracks or other areas of potential hazard.

Any devises found to be in need of repair will be addressed immediately.

A listing of all items found to be in need of repair or replacement shall be reported to the Quality Assurance Committee quarterly one year.

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) Sister Phyllis McCracken, President/CEO — Date 9-25-17

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The above plan of correction is approved as of 10/20/17 (Date)

The above plan of correction was approved by (Initials)

Plan of correction implementation status as of 10/20/17 (Date)

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

Violation Report: 41342 - 08/29/2017 - Flinner-Alman, Lisa
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
2600.85(a) - Sanitary conditions shall be maintained.

2a. DESCRIPTION OF VIOLATION
The home has a "house glucometer" that was used to measure the blood glucose of multiple unidentified residents including the following dates:

- 6/15/17 at 11:02 a.m.
- 6/28/17 at 2:52 p.m.

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.

"House Glucometer" was immediately taken out of use.

Staff have been educated to ensure that each individual will have their own glucometer and if a new glucometer is opened / used for emergency use on a resident that previously did not have their own glucometer, it shall not be terminally cleaned and reused but will be labeled for permanent use for that individual only or be disposed of immediately.

Each glucometer has been labeled for individual use by that resident only.

Personal Care Home Administrator (PCHA) to retain new "emergency glucometer" in the Director's Office and will assist staff in properly labeling it, should it need to be used for a particular resident.

All glucose monitors will be audited monthly by PCHA to ensure that they remain in use for that particular resident only.

The results of this audit will be reported to the Quality Assurance Committee quarterly for one year.

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(Required on EVERY Page) Sister Phyllis McCracken, President/CEO — Date 9-25-17

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Violation Report: 41342 - 08/29/2017 - Finnar-Alman, Lisa
POH Name: SAINT MARY S AT ASBURY RIDGE

SEP 25 2017
WEST REGION FIELD OFFICE
Human Services Licensing

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 drill conducted on 4/24/17 at 1:35 p.m., does not include the amount of time for the evacuation.

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 record for fire drills conducted 7/31/17, 8/24/17, 9/28/17 and 10/13/17 include the amount of time to evacuate the home. [initials] 10/20/17

The Personal Care recommended fire drill log will be implemented in October 2017. This log will then contain all the required data thus eliminating missing information.

The Maintenance Team Leader will review the log following each drill to ensure that the log is complete.

The Maintenance Team Leader will report the finding of the logs to the Quality Assurance Committee quarterly for one year.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/07/2016 etal		

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SAINT MARY'S ASBURY

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

Twelve minutes is the home's maximum evacuation time, as designated in writing by a fire safety expert on 10/13/16. The home exceeded this evacuation time during fire drills on the following dates:

-11/8/16 at 2:18 p.m., evacuation time - 21 minutes
- 3/13/17 at 1:00 a.m., evacuation time - 19 minutes

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.

Personal Care recommended fire drill log will be implemented in October 2017. This log will then contain all the required data including the maximum evacuation times.

The Maintenance Team Leader will review the log following each drill to ensure that the log is completed correctly.

The Maintenance Team Leader will conduct a fire evacuation in-service with the residents during their October Resident Council Meeting.
The Personal Care Staff will be in-serviced by the Personal Care Home Administrator (PCHA) regarding fire evacuation by October 20, 2017.

The Maintenance Team Leader will report the finding of the logs to the Quality Assurance and Assessment Committee quarterly for one year.

Fire drills conducted on 7/31/17, 8/24/17, 9/28/17 and 10/13/17 had evacuation times under 12 minutes. [initials] 10/20/17

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Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/07/2016 [initials]

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Violation Report: 41342 - 08/29/2017 - Filner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.132(h) - Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

2a. DESCRIPTION OF VIOLATION
According to multiple resident and staff interviews, residents on the secured dementia care unit (SDCU) are evacuated to the central lounge area. This area was not designated in writing as a fire safe area by a fire safe expert in the letter dated 10/17/16.

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.

On September 27, 2017 Fire Safety Expert will inspect the Personal Care Alzheimer's Unit and designate the fire safe area for evacuation. The 2017 letter will designate all fire safe areas for the Personal Care Area.

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Violation Report: 41342 - 08/29/2017 - Filner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
(1) The resident's name.
(2) The name of the medication.
(3) The date the prescription was issued.
(4) The prescribed dosage and instructions for administration.
(5) The name and title of the prescriber.

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2a. DESCRIPTION OF VIOLATION

Resident #2 is ordered Calcium Carbonate Chewable 1000mg, chew 1/2 a tablet twice a day. However, the label indicates 500mg, chew 1 tablet twice a day.

Resident #3 is ordered Furosemide 60mg, 1 tablet daily. However, the label indicates 20mg, 3 tablets daily.

Resident #3 is ordered Enalapril 2.5mg, 1 tablet daily. However, the label indicates 1 tablet twice a day.

Resident #3 is ordered Potassium Chloride 10 mEq ER, 2 capsules Monday, Wednesday, Friday and Sunday. However, the label indicates 1 tablet.

Resident #3 is ordered Atenolol 25mg, 1 tablet daily. However the label indicates 1 tablet twice a day.

All nurses were educated to understand that the medication label must accurately reflect the correct resident name, medication name, prescription issue date, dosage and instructions for administration and the name and title of the prescriber.

A whole-house audit of all resident medication orders was completed by 8/7/17. All current medications have been reviewed by the nursing staff individually to ensure that the physician order and the pharmacy label are a complete match.

All medication orders that did not have a corresponding matching label were corrected.

A nightly audit of all new orders is performed to ensure continued accuracy by the nurse performing the final "redline" of the charts and a 24 item checklist has been issued to each nurse to complete on his / her assigned section of the medication carts weekly to ensure on-going compliance.

All delivered medications will be compared to the active resident orders for accuracy and initialed by the RN / LPN once verified to be accurate prior to placing them in the medication cart.

The results of these audits will be reported to the Quality Assurance Committee quarterly for one year.

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(Required on EVERY Page) Sister Phyllis McCracken

Printed Name and Title of Legal Entity Representative
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Date 9-25-17

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Plan of correction implementation status as of 10/20/17 (Date)

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Violation Report: 41342 - 06/29/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.185(a) - The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

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2a. DESCRIPTION OF VIOLATION
Resident #1's glucometer was not calibrated to the correct time.

Resident #4's glucometer was not calibrated to the correct date and time.

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.

All glucometers have since been calibrated to reflect the correct date and time.

All nurses have been educated regarding the need for accurate date and time calibration on glucometers to authenticate all numbers reviewed in the glucometer memory.

Staff nurses will monitor continued calibration nightly with each use and Personal Care Home Administrator will monitor / document continued compliance monthly

The results of this monitor will be reported to the Quality Assurance Committee quarterly for one year .

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

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Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Sister Phyllis McCracken, President/CEO — Date 9-25-17

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Plan of correction implementation status as of 10/20/17 (Date)

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- ☐ Not Implemented

Violation Report: 41342 - 06/29/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

(1) Resident's name.
(2) Drug allergies.
(3) Name of medication.
(4) Strength.
(5) Dosage form.
(6) Dose.
(7) Route of administration.
(8) Frequency of administration.
(9) Administration times.
(10) Duration of therapy, if applicable.
(11) Special precautions, if applicable.
(12) Diagnosis or purpose for the medication, including pro re nata (PRN).
(13) Date and time of medication administration.
(14) Name and initials of the staff person administering the medication.

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Human Services Licensing

2a. DESCRIPTION OF VIOLATION

The June 2017 medication administration record (MAR) for resident #2 does not include a diagnosis or purpose for Polyethylene Glycol 3350 powder 17gms.

The June 2017 MAR for resident #3 does not include a diagnosis or purpose for Furosemide 60mg.

All nurses were educated regarding the need for proper diagnosis with each medication order.
A whole-house audit of all medication orders to ensure proper diagnosis was completed by 8/7/17.

A nightly audit of all new orders is performed by the night nurse to ensure that all new medications have a proper diagnosis prior to the final "redlining" process.

All insulin orders were immediately updated in our EMAR system to include a documentation area for the nurse to indicate exactly how many units of insulin were administered based upon the corresponding sliding scale.

All new sliding scale insulin orders are monitored by the night shift nurse with her aforementioned final redlining process to ensure that a designated area has been assigned in the EMar with the SSI order to indicate the number of units administered.

All residents with sliding scale orders will have their EMar monitored weekly to ensure proper documentation of units given.
The results of these monitors will be reported to the Quality Assurance Committee quarterly x 3.

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

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Sister Phyllis McCracken, President/CEO	Date 9-25-17

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Plan of correction implementation status as of 10/20/17 (Date)

- [ ] Fully Implemented
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Violation Report: 41342 - 08/29/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

SEP 25 2017
WEST REGION FIELD OFFICE
Human Services Licensing

1. REGULATION 55 Pa.Code §2600
2600.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

2a. DESCRIPTION OF VIOLATION
Resident #6 was admitted [redacted]; however, the preadmission screening was completed on 2/3/17.

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.

All resident screens to be reviewed by PCHA to ensure that each was completed within the proper time frame prior to 10/1/2017.
A checklist has been created to ensure that all resident pre-screens are completed no sooner than 30 days prior to admission so that a proper determination can be made regarding the home's ability to meet the needs of the potential resident.
All admissions are tracked on a daily basis and PCHA will verify timeliness of pre-screen documentation with each new admission.
The results of this monitor will be reported to the Quality Assurance Committee quarterly x 3.

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

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

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

Plan of correction implementation status as of 10/26/17 (Date)

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

Violation Report: 41342 - 08/29/2017 - Filnner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

SEP 25 2017
WEST REGION FIELD OFFICE
Human Services Licensing

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 2/16/17, for resident #7 does not include the diagnoses of edema, debility, lumbar compression fracture, hemorrhoids, hyperlipidemia and use of wheeled walker and bedside enabler, as indicated on the medical evaluation, dated 2/16/17.

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 # 7's RASP was updated to include the diagnoses of edema, debility, lumbar compression fracture, hemorrhoids, hyperlipidemia and use of wheeled walker and bedside enabler as indicated on the DME.

All RASPs to be audited by 10/20/2017 for inclusion of all appropriate diagnoses, using the DME as the guide. Upon receipt of all new DMEs, a new RASP will be created based upon that DME.

The results of these audits will be reported to the Quality Assurance Committee quarterly for one year.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	06/07/2016		

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(Required on EVERY Page) Sister Phyllis McCracken

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Date 9-25-17

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Violation Report: 41342 - 08/29/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY S AT ASBURY RIDGE

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Human Services Licensing

1. REGULATION 55 Pa.Code §2600

2600.225(c) - The resident shall have additional assessments as follows:
(1) Annually.
(2) If the condition of the resident significantly changes prior to the annual assessment.
(3) At the request of the Department upon cause to believe that an update is required.

2a. DESCRIPTION OF VIOLATION

The assessment, dated 2/17/17, for resident #2 does not include the diagnoses of constipation, anxiety, methicillin-resistant staphylococcus aureus (MRSA) nasal, glaucoma, pain, osteoporosis, paranoia, edema, other specified mental disorder and bipolar disorder that are indicated on the medical evaluation, dated 11/10/16.

The assessment, dated 2/17/17, for resident #2 indicates "not applicable" for the resident's ability to to use and avoid poisons. However, the resident resides on the secured dementia unit, and the medical evaluation, dated 11/10/16, indicates the resident cannot safely use and avoid poisons.

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 # 2's RASP was updated to include the diagnoses of constipation, anxiety, nasal MRSA, glaucoma, pain, osteoporosis, paranoia, edema , other specified mental disorder and Bipolar disorder as indicated on the DME.

All RASPs to be audited by 10/20/2017 for inclusion of all appropriate diagnoses, using the DME as the guide. Upon receipt of all new DMEs, a new RASP will be created based upon that DME.

All RASPs to be audited by 10/20/2017 to ensure the accuracy of the resident's ability to safely use poisons based upon the DME

The results of these audits will be reported to the Quality Assurance Committee quarterly for one year.

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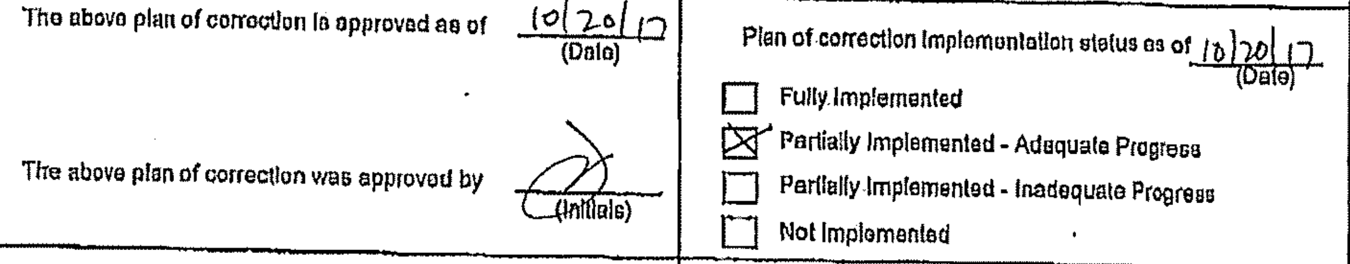
(Required on EVERY Page) Sister Phyllis McCracken

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Sister Phyllis McCracken, President/CEO — Date 9-25-17



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Violation Report: 41342 - 08/28/2017 - Flinner-Alman, Lisa
PCH Name: SAINT MARY'S AT ASBURY RIDGE

1. REGULATION 55 Pa.Code §2600
2600.231(c) - A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
The written cognitive preadmission screening was undated on the preadmission screening, dated [redacted], for resident #3.

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 cognitive screen was accurately updated to include the cognitive screen date of [redacted].

All cognitive screens of those residents requiring the safety and security of our dementia care unit have been reviewed to ensure date accuracy and timeliness.

All admissions to the Secured Dementia Unit will have the proper date recorded on the cognitive screen portion of their preadmission screening form.

This process will be further strengthened by the use of the admission / significant change checklist forms.

All new admissions to the Secured Dementia Unit will be audited to ensure the cognitive screen was properly dated and the results of this audit will be reported to the Quality Assurance Committee quarterly for one year.

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): Sister Phyllis McCracken, President/CEO — Date: 9-25-17

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The above plan of correction is approved as of 10/20/17 (Date)

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

Plan of correction implementation status as of 10/20/17 (Date)

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