Department of Human Services
Bureau of Human Service Licensing

January 3, 2022

[redacted]
SAINT MARY'S HOME OF ERIE
1781 WEST 26TH STREET
ERIE, PA, 16508

RE: SAINT MARY'S AT ASBURY RIDGE
4855 WEST RIDGE ROAD
ERIE, PA, 16506
LICENSE/COC#: 41342

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/28/2021, 07/29/2021, 07/30/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *SAINT MARY'S AT ASBURY RIDGE* **License #:** *41342* **License Expiration:** *10/27/2021*

Address: *4855 WEST RIDGE ROAD, ERIE, PA 16506*

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

Administrator

Name: [redacted] **Phone:** *814-836-5421* **Email:** [redacted]

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *07/12/2006* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *84* **Waking Staff:** *63*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date:** *07/30/2021*

Inspection Dates and Department Representative

07/28/2021 - On-Site: [redacted]

07/29/2021 - On-Site: [redacted]

07/30/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *164* **Residents Served:** *43*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *MEMORY CARE* **Capacity:** *16* **Residents Served:** *15*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *42*
Diagnosed with Mental Illness: *1*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *41*
Have Physical Disability: *0*

Inspections / Reviews

07/28/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *09/26/2021*

Inspection Dates and Department Representative *(continued)*

11/04/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *11/12/2021*

12/22/2021 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *12/30/2021*

01/03/2022 - Document Submission

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

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

On 7/30/21, direct care staff person A, hired on [redacted], did not have a high school diploma, GED, or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction ***Accept***

1. High school diploma copy requested from employee A – received and added to employee file by 8/2/2021.
2. All residential living human resources files were audited for proof of high school diplomas by 10/1/2021.
3. Human resources director/designee will audit records for newly hired staff ensuring proof of high school diploma is present at time of hire.
4. Human resources director/designee will report initial audit findings to Quality Assessment and Assurance Committee monthly for 3 months, then quarterly.

Completion Date: *10/01/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *10/01/2021*

81b - Resident Personal Equipment

1. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 7/28/21, the approximate 12" x 6" opening between the rails of the uncovered enabler bar attached to resident #1's bed posed an entrapment hazard.

On 7/28/21, the approximate 7 1/2" x 4" opening between the rails of the uncovered enabler bar attached to resident #2's bed posed an entrapment hazard.

Plan of Correction ***Accept***

1. Covers will be placed on bed enabler by 10/05/2021.
2. A list of residents with bed enablers/canes will be posted in the nursing office. Nurses/Certified Medication Technicians will complete weekly checks for covers and document on audit sheet developed by PCHA beginning 10/05/2021.
3. PCHA/designee will monitor audits and report findings to Quality Assessment and Assurance Committee monthly for 3 months, then quarterly.

Completion Date: *10/05/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *10/05/2021*

82c - Locking Poisonous Materials

1. Requirements

2600.
82.c. Poisonous materials shall be kept locked and inaccessible to residents unless all of the residents living in the home are able to safely use or avoid poisonous materials.

Description of Violation

On 7/28/21, a spray bottle of Alpha HP multi surface disinfectant cleaner with a manufacture's label indicating "If swallowed call poison control center or a physician", was unlocked, unattended and accessible to residents in the kitchenette top cabinet in the Memory Care secured dementia care unit (SDCU). Resident #3 and resident #4 reside in the Memory Care SDCU and are not assessed capable of recognizing and using poisons safely.

Plan of Correction ***Accept***

1. Alpha HP multi-surface cleaner immediately removed and placed in secure cupboard at time of survey.
2. PCHA/designee will develop and implement an education review regarding the use of poisonous substances in the secure dementia unit for all residential staff by 10/05/2021.
3. PCHA/designee will complete weekly rounds in the secure dementia unit and audit compliance.
4. PCHA/designee will report audit findings to the Quality Assurance and Assessment Committee monthly for 3 months and then quarterly.

Completion Date: *10/05/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *10/05/2021*

95 - Furniture and Equipment

1. Requirements

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 7/28/21, the double fire doors near the Memory Care SDCU dining area slammed shut with force, creating a potential hazard to residents. The doors were also approximately ½" off set from each other and misaligned.

Plan of Correction ***Accept***

1. Maintenance notified of potential hazard posed by doors in the secure dementia unit
2. Maintenance will adjust the dining area door to decrease the speed at which the door closes by 10/05/2021.
3. Maintenance will adjust the alignment of the fire doors between the secure dementia unit and the hallway to the kitchen by 10/05/2021,
4. Maintenance will conduct twice a month audits regarding door closure speed and alignment of fire doors twice a month for three months, then monthly.
5. Maintenance director will report findings to Quality Assessment and Assurance Committee monthly for three months and then quarterly.

Completion Date: *10/05/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *10/05/2021*

95 - Furniture and Equipment *(continued)*

141b1 - Annual Medical Evaluation

1. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

On 7/30/21, resident #2's most recent annual medical evaluation was conducted on [redacted] *However the resident's previous evaluation was conducted on* [redacted]

Plan of Correction ***Accept***

1. Resident #2 was on leave of absence during the time period indicated in the survey.
2. On 11/28/2020 resident was sent to UPMC Hamot for treatment and admitted to acute care.
3. On 12/1/2020 resident returned to Saint Mary's Home requiring skilled nursing services.
4. Resident remained in skilled nursing until 2/11/2021 when he returned to personal care services.
5. DME was completed on 2/15/2021 within regulation requirements.
6. PCHA/designee will complete an initial audit of all current resident charts for current and accurate DMEs by 11/16/2021; after initial audit – subsequent audits will be completed on all new admissions, change of condition and yearly DMEs twice a month.
7. The results of this audit will be reported quarterly to the QAA Committee
Completion Date: *11/16/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *11/16/2021*

183d - Prescription Current

1. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 7/29/21, resident #2's bottle of [redacted] *in the medication cart, labeled with a "Directions changed refer to chart" sticker and a post-it note indicating "Save for possible one time dose while checking blood glucose next 2 weeks – 6/16/21". However, this medication was discontinued 6/15/21.*

Plan of Correction ***Accept***

1. Expired medications immediately removed from medication carts at time of survey.
2. Medication and medication cart audits were developed and implemented by PCHA beginning August 16, 2021.
3. Nurses and certified medication technicians will complete a weekly audit as assigned by PCHA/designee. Calendar located in medication room. Audits will cover each shift and each cart at least monthly.
4. PCHA/designee will maintain audits and review weekly. Report to Quality Assurance and Assessment monthly for 3 months and then quarterly.

Completion Date: *08/16/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *08/16/2021*

184a - Labeling OTC/CAM

1. Requirements

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.

Description of Violation

Resident #5 is prescribed [redacted] Per sliding scale subcutaneous per sliding scale: 181-250= 3 units, 251-300= 6 units, 301-350= 9 units, 351-400= 12 units, call DR if CS<60 or >400, twice daily 11:00, 16:00. However, the resident's medication label indicates: Lispro (Humalog kwikpen) Injection 100/ml – Inject 5 units subcutaneously three times daily as needed per sliding scale: 181-250= 3 units, 251-300= 6 units, 301-350= 9 units, 351-400= 12 units, call DR if CS<60 or >400.

Resident #5 is prescribed [redacted] – take 1 cap by mouth twice daily as needed. However, the resident's medication label indicates: [redacted] – take one cap by mouth twice daily.

Resident #5 is prescribed [redacted] – take one tab by mouth oral three times daily weekly on Tuesday, Thursday, Saturday 12:00, 16:00, 20:00 and [redacted] – one tab by mouth oral three times daily weekly on Monday, Wednesday Friday Sunday 06:00, 16:00, 20:00. However, the resident's medication label indicates: [redacted] – take one tablet by mouth three times daily – do not lie down for four hours after taking.

Resident #5 is prescribed [redacted] – 1 cap oral (Give at noon on Tuesday, Thursday and Saturday) Twice daily weekly on Tuesday, Thursday, Saturday 12:00, 20:00. However, the resident's medication label indicates: [redacted] – take 1 capsule by mouth twice daily.

Plan of Correction ***Accept***

1. Medication orders will be reconciled with medication labels by 10/5/2021.
2. A request to resident #5 physician to align all medications to the same times every day will be completed by 10/5/2021
3. Medication and medication cart audits were developed and implemented by PCHA beginning August 16, 2021. The audit includes checking the medication labels and orders match.
4. Nurses and certified medication technicians will complete a weekly audit as assigned by PCHA/designee. Calendar located in medication room. Audits will cover each shift and each cart at least monthly.
5. PCHA/designee will maintain audits and review weekly. Report to Quality Assurance and Assessment monthly for 3 months and then quarterly.
Completion Date: *10/05/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *10/05/2021*

185a - Implement Storage Procedures

1. Requirements

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.

Description of Violation

Resident #1 is prescribed [redacted] – take one tab every 6 hours as needed for pain. However, on 7/29/21, the medication was not available in the home.

Plan of Correction ***Accept***

1. Resident #1 had order for prn use of [redacted]. Medication discontinued 7/31/2021 by physician due to non-use. This medication was removed at the time of survey.
2. Medication and medication cart audits were developed and implemented by PCHA beginning August 16, 2021. The audit includes checking the medication cart for all medications (both routine and prn) being available for resident use.
3. Nurses and certified medication technicians will complete a weekly audit as assigned by PCHA/designee. Calendar located in medication room. Audits will cover each shift and each cart at least monthly.
4. PCHA/designee will maintain audits and review weekly. Report to Quality Assurance and Assessment monthly for 3 months and then quarterly.
Completion Date: *08/16/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *08/16/2021*

2. Requirements

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.

Description of Violation

On 7/16/21 at 11:34 a.m. resident 5's blood glucose level was 127; however, the resident's July 2021 medication administration record (MAR) indicates the resident's blood glucose level was 124.

On 7/19/21 at 11:13 a.m. resident #5's blood glucose level was 98; however, the resident's July 2021 MAR indicates the resident's blood glucose level was 96.

On 7/20/21 at 12:14 p.m. resident #5's blood glucose level was 110; however, the resident's July 2021 MAR indicates the resident's blood glucose level was 111.

On 7/28/21 at 3:56 p.m. resident #5's blood glucose level was 263; however, the resident's July 2021 MAR indicates the resident's blood glucose level was 265.

Plan of Correction ***Accept***

1. Medication administration staff verbally counseled regarding importance of accuracy in transcription of glucometer readings to eMAR by PCHA during survey process.
2. PCHA/designee will develop and implement an education review covering the importance of documenting accurate blood glucose results by 10/10/2021.
3. Night shift nurse or certified medication technician will complete weekly audits comparing blood glucose readings from glucometer to documentation in the eMAR. PCHA/designee will review audits weekly for compliance.

185a - Implement Storage Procedures (continued)

4. PCHA/designee will report audit findings to the Quality Assurance and Assessment Committee monthly for 3 months and then quarterly.

Completion Date: *10/08/2021*

Document Submission ***Implemented***

See POC above

Completion Date: *10/08/2021*

224a - Preadmission Screen Form

1. Requirements

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.

Description of Violation

Resident #5's pre-admission screening is unsigned and undated by the assessor and it cannot be determined if it was completed timely.

Plan of Correction ***Accept***

1. Upon review of the documentation in the chart the preadmission evaluation took place on 5/4/2021 as reflected in the Saint Mary's preadmission assessment. The DPW form was corrected with required information.
2. The PCHA/unit secretary will audit each preadmission assessment for date and signature on admission.
3. All current residents were audited for preadmission assessment completion – all were found to be in compliance for date/signature on 8/4/2021
4. PCHA/designee will report audit findings to the Quality Assurance and Assessment Committee monthly for 3 months and then quarterly.

Completion Date: *08/04/2021*

Document Submission ***Implemented***

See POC above

Completion Date: *08/04/2021*

225c - Additional Assessment

1. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

On 7/30/21, resident #2's annual assessment was completed on [redacted] *However the resident's previous assessment was completed on* [redacted].

Plan of Correction ***Accept***

1. Resident #2 was on leave of absence during the time period indicated in the survey.
2. On 11/28/2020 resident was sent to UPMC Hamot for treatment and admitted to acute care.
3. On 12/1/2020 resident returned to Saint Mary's Home requiring skilled nursing services.
4. PCHA/designee will complete an initial audit of all current resident charts for current and accurate RASPs by

225c - Additional Assessment (continued)

11/16/2021; after initial audit – subsequent audits will be completed on all new admissions, change of condition and yearly RASPs twice a month.
5. The results of the audit will be reported quarterly to the QAA Committee.

7. PCHA/designee will complete an initial audit of all current resident charts for current and accurate RASPs by 11/16/2021; after initial audit – subsequent audits will be completed on all new admissions, change of condition and yearly RASPs twice a month.

4. Resident remained in skilled nursing until 2/11/2021 when he returned to personal care services.
5. DME was completed on 2/15/2021 within regulation requirements.

Completion Date: *11/16/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *11/16/2021*

227d - Support Plan Medical/Dental

1. Requirements

2600.
227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

Resident #2 uses a bed enabler which is installed on the resident's bed. However, the resident's current support plan, dated 2/17/21, does not indicate use of this device.

Plan of Correction ***Accept***

1. Physician request sent 9/22/2021 for bed enabler.
2. All resident charts have been reviewed for use of bed cane and physician orders 9/22/2021 with orders noted.
3. PCHA/designee to audit all charts for bed enabler orders monthly.
4. PCHA/designee will complete an initial audit of all current resident charts for current and accurate RASPs for use of bed enablers by 11/16/2021; after initial audit – subsequent audits will be completed on all new admissions, change of condition and yearly RASPs twice a month.
4. PCHA/designee will report audit findings to Quality Assurance and Assessment Committee monthly for 3 months and then quarterly.

Completion Date: *11/16/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *11/16/2021*

233c - Key-Locking Devices

1. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

Description of Violation

On 7/28/21, the exit code instructions were not posted at the locked doors exiting from the Memory Care unit to the hallway leading to the main kitchen and dining area.

Plan of Correction ***Accept***

1. Maintenance notified of missing exit code instructions in secure dementia unit exit door to hallway, new sign posted on 09/1/2021
2. Maintenance will conduct twice a month audits regarding door closure speed and alignment of fire doors twice a month for three months, then monthly.
3. Maintenance director will report findings to Quality Assessment and Assurance Committee monthly for three months and then quarterly.

Completion Date: *09/01/2021*

Document Submission ***Implemented***

See POC above
Completion Date: *09/01/2021*