

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

December 27, 2024

[REDACTED], CEO
SAINT MARY'S HOME OF ERIE
[REDACTED]

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 10/03/2024 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: SAINT MARY'S AT ASBURY RIDGE License #: 41342 License Expiration: 10/27/2025
 Address: 4855 WEST RIDGE ROAD, ERIE, PA 16506
 County: ERIE Region: WESTERN

Administrator

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

Legal Entity

Name: SAINT MARY'S HOME OF ERIE
 Address: [REDACTED]
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

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

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 120 Waking Staff: 90

Inspection Information

Type: Full Notice: Unannounced BHA Docket #:
 Reason: Renewal Exit Conference Date: 10/03/2024

Inspection Dates and Department Representative

10/03/2024 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: 164 Residents Served: 61

Secured Dementia Care Unit
 In Home: Yes Area: Memory Care Capacity: 16 Residents Served: 16

Hospice
 Current Residents: 0

Number of Residents Who:
 Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 61
 Diagnosed with Mental Illness: 1 Diagnosed with Intellectual Disability: 0
 Have Mobility Need: 59 Have Physical Disability: 0

Inspections / Reviews

10/03/2024 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 11/03/2024

11/13/2024 - POC Submission
 Submitted By: [REDACTED] Date Submitted: 12/12/2024
 Reviewer: [REDACTED] Follow-Up Type: Document Submission Follow-Up Date: 12/13/2024

Inspections / Reviews *(continued)*

12/27/2024 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 12/12/2024

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

18 - Compliance With Laws

1. Requirements

2600.

18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.

The fossil fuel burning dryer in the basement level main laundry room was approximately 12 feet from the carbon monoxide detector.

Plan of Correction

Accept (█ - 11/13/2024)

1. *The carbon monoxide detector that was approximately 12 feet from the fossil-fuel burning dryer in the basement level main laundry room was removed by maintenance and placed 15.5 feet away from the fossil-fuel burning dryer. Completed: 10/03/2024*

2. *The Maintenance Supervisor and/or designee will complete a monthly QAA monitor to assure that all carbon monoxide alarms will be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance.*

3. *This QAA monitor will be completed monthly for three consecutive months and reported at the monthly QAA meeting. If the QAA monitor reflects 100% compliance for three consecutive months, then the QAA monitor may be completed on a quarterly basis.*

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█ - 12/27/2024)

26b - Quality Management Plan Content

2. Requirements

2600.

26.b. The quality management plan shall address the periodic review and evaluation of the following:

1. The reportable incident and condition reporting procedures.
2. Complaint procedures.
3. Staff person training.
4. Licensing violations and plans of correction, if applicable.
5. Resident or family councils, or both, if applicable.

Description of Violation

The home's quality management review meeting completed 11/14/23 did not address reporting of reportable incidents, complaint procedures, staff training, resident and/or family councils.

Plan of Correction

Accept (█ - 11/13/2024)

Staff members responsible for monthly reporting to QAA include Corporate Compliance Officer, Activities Director, Maintenance Supervisor, Dietary Director and the PCHA. These team members have been provided with the updated QAA Agenda that delineates their reporting responsibilities as follows:

1. *Reportable incidents: PCHA*

26b - Quality Management Plan Content (continued)

- 2. Complaint procedures: PCHA
- 3. Staff person training: Compliance Officer
- 4. Licensing violations and plan of correction: PCHA, Maintenance Supervisor, Dietary Director.
- 5. Resident Council: Activity Director.

The QAA Agenda will be updated to reflect these monthly reporting elements for the QAA meeting scheduled the second Tues of each month, beginning with the Nov 12, 2024 QAA meeting.

The PCHA will oversee this process and maintain the documents for validation monthly to include the QAA agenda, the formatted reporting for each item and any follow up necessary. These files will be maintained by the PCHA for POC along with a copy in the facilities master file as is our current practice.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented (█) - 12/27/2024)

81b - Resident Personal Equipment

3. 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

The cover on the enabler bar on resident #1's bed was seated partially down the frame, exposing an opening of 3.75" x 5.75", posing an entrapment hazard.

Repeat Violation: 10/4/23

Plan of Correction

Accept (█) - 11/13/2024)

Resident #1 has been educated by the PCHA on 10-29-2024 of the need to properly utilize the bedrail cover and the need to have it pulled to the top of the rail to prevent a gap that is a potential entrapment hazard. The nursing staff will monitor the position of his bedrail cover daily for compliance and this will be documented in the EMAR as validation of compliance.

All nursing staff will be educated by the PCHA on the standard that all bedrail covers must be pulled to the top of the rail at all times to prevent a gap that is a potential entrapment hazard by 11-11-2024.

All enablers will be assessed by the PCHA and a second professional upon admission and on a monthly basis to ensure that they do not pose an entrapment hazard for the residents. Initial assessment and documentation will be completed by 11-11-2024. This information will be reported to the QAA committee monthly under the POC monthly reporting agenda item.

Licensee's Proposed Overall Completion Date: 11/11/2024

Implemented (█) - 12/27/2024)

86a - Ventilation

4. Requirements

2600.

86.a. All areas of the home that are used by the resident shall be ventilated. Ventilation includes an operable window, air conditioner, fan or mechanical ventilation that ensures airflow.

Description of Violation

At 12:40 p.m., the UHT hallway common area men's bathroom has no operable window, fan, air conditioner or other mechanical ventilation to ensure airflow.

Plan of Correction

Accept ([redacted] - 11/13/2024)

1. The Maintenance Supervisor discovered that the manual damper in the men's bathroom was closed which blocked the mechanical ventilation to ensure airflow. Completed: 10/23/2024

2. The Maintenance Supervisor and/or designee will inspect all areas of ventilation in the residents' public restrooms to ensure that there is operable mechanical ventilation to ensure airflow.

3. This QAA monitor will be completed monthly and reported at the monthly QAA meeting. If the QAA monitor reflects 100% compliance for three consecutive months, then the QAA monitor may be completed on a quarterly basis.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented ([redacted] - 12/27/2024)

92 - Windows

5. Requirements

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

At 11:52 a.m., there was an approximate 1/8" x 2" tear in the bottom middle section of the right window screen in the common area of bedroom #2117.

Plan of Correction

Accept ([redacted] - 11/13/2024)

1. The screen with the tear in room #2117 was replaced by maintenance on 10/03/2024.

2. The Maintenance Supervisor and/or designee will inspect all window screens in Residential Living apartments on a monthly basis to ensure all screens are in good repair and securely screened.

3. This QAA monitor will be completed on a monthly basis and reported at the monthly QAA meeting.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented ([redacted] - 12/27/2024)

103e - Left Overs

6. Requirements

2600.

103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 11:39 a.m., there was an open and undated bag of twenty sausage links in the white ice cream freezer in the kitchen.

At 11:41 a.m., the seal was broken on a bag of approximately 15 stuffed cabbage rolls in the walk in the freezer.

Plan of Correction

Accept (█ - 11/13/2024)

1. *The open and undated bag of sausage links was discarded by the Dietary Manager on 10/03/2024*

2. *The cabbage rolls with the broken seal were also discarded by the Dietary Manager on 10/03/2024*

3. *A mandatory in-service regarding food safety requirements which includes storage, preparation, labeling, dating and distribution of food in accordance with professional standards for food safety will be performed by the Dietary Manager and/or designee and be completed by 11/22/2024*

4. *The Dietary Manager and/or designee will conduct daily monitoring of all freezers to ensure proper storage, labeling and dating of all food items.*

The Dietary Manager and or designee will complete this QAA monitor daily for twelve consecutive months and report the findings to the monthly QAA Committee on a monthly basis.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█ - 12/27/2024)

121a - Unobstructed Egress

7. Requirements

2600.

121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

At 12:27 p.m., 2 resident chairs blocked the courtyard exit of the secured dementia care unit.

Plan of Correction

Accept (█ - 11/13/2024)

1. *The 2 (two) resident chairs blocking the courtyard exit in the secured dementia care unit were removed by maintenance staff on 10/03/2024*

2. *All staff on the secured dementia memory care unit will be educated regarding unobstructed stairways, hallways, doorways, passageways and egress routes from rooms and from the building and completed by 11/29/2024*

3. *The maintenance Supervisor and/or designee will monitor hallways, doorways, passageways and egress routes from rooms and from the building in the secured dementia memory care unit to ensure an unobstructed egress.*

121a - Unobstructed Egress (continued)

This monitor will be completed daily for one week, then weekly for four weeks and reported at the monthly QAA meeting. If the monitor reflects 100% compliance, then the monitor may be completed on a quarterly basis.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 12/27/2024)

132a - Monthly Fire Drill

8. Requirements

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of January 2024.

Plan of Correction

Accept (█) - 11/13/2024)

The Maintenance Supervisor will conduct unannounced fire drills on a monthly basis.

The Maintenance Supervisor will log the monthly unannounced fire drills. The Maintenance Supervisor will meet with the Administrator on or before the 15th of every month to monitor and review that the unannounced fire drills are occurring on a monthly basis.

The Maintenance Supervisor will complete this monitor monthly with the Administrator on or before the 15th of the month and report the findings to the monthly QAA meeting.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 12/27/2024)

132c - Fire Drill Records

9. Requirements

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.

Description of Violation

The home's fire drill records do not indicate the exit route used for multiple fire drills, to include 7/31/24 at 1:41 p.m. and 8/27/24 at 4:30 PM.

The home's fire drill record for the drill conducted 3/27/24 at 1:00 a.m. does not indicate the amount of time it took for evacuation.

Plan of Correction

Accept (█) - 11/13/2024)

The Maintenance Supervisor has replaced the fire drill record form with the Adult Residential Licensing-Personal Care Home, Fire Drill Record- 55Pa. Code 2600.132 (c) which includes, the date, time, the amount of time it took

132c - Fire Drill Records (continued)

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.

The Maintenance Supervisor and/or designee will utilize the Personal Care Regulation Fire Drill Record every time a fire drill is exercised, which would be no less than monthly.

The Maintenance Supervisor will complete a monthly QAA monitor and report the findings to the monthly QAA meeting.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 12/27/2024)

132d - Evacuation

10. Requirements

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. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

The home's maximum safe evacuation time as determined by a fire safety expert on 10/3/23 is 10 minutes. However, the home exceeded this time during the following fire drills:

11/21/23 at 9:06 p.m. - 11 minutes

12/17/23 at 11:15 p.m. - 30 minutes

2/22/24 at 5:04 p.m. - 11 minutes

6/27/24 3:30 a.m. - 30 minutes

Plan of Correction

Accept (█) - 11/13/2024)

The Maintenance Supervisor and Department Managers will meet to discuss Residential Living/Personal Care fire drills which will include the new fire drill record form and maintaining the home's maximum safe evacuation time of 10 minutes. This group will meet on a weekly basis to determine all staff's involvement in Personal Care fire drill evacuation to ensure staff are given the correct directives on evacuation in Personal Care, resulting in a safe evacuation time of 10 minutes or less.

An investigation recently revealed that all staff in the building have not been participating actively in Personal Care fire drills. All staff will be in-serviced and re-educated on Personal Care fire drills and the maximum safe time of ten minutes or less.

The Maintenance Supervisor will meet with the Administrator on or before the 15th of every month to determine if the home's maximum safe evacuation time was met. If the home's maximum safe evacuation time of 10 minutes is not met the drill will be repeated until the maximum safe evacuation time is met.

The Maintenance Supervisor will monitor the fire drills as they occur, and monthly and report the findings to the QAA committee on a monthly basis

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█) - 12/27/2024)

132d - Evacuation (continued)

141a 1-10 Medical Evaluation Information

11. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

Resident #1's initial medical evaluation, dated [REDACTED] does not indicate the resident's health status. This section of the form is blank.

Plan of Correction

Accept ([REDACTED] - 11/13/2024)

Resident #1's medical evaluation was updated by the CRNP on 10-29-2024 with all sections properly completed.

The PCAH will complete chart review for all current residents to ensure that all medical evaluations have all areas completed with proper documentation. Any areas not completed properly will be addressed by the physician, physician’s assistant or CRNP for proper completion of this form.

The PCHA, along with a second professional, will monthly review all active charts for proper completion of the current medical evaluation for each resident. This information will be reported to the QAA committee monthly under the POC monthly reporting agenda item.

Licensee's Proposed Overall Completion Date: 11/11/2024

Implemented ([REDACTED] - 12/27/2024)

171b5 - First Aid Kit

12. Requirements

2600.

171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the 2014 Chrysler Caravan used to transport residents does not include antiseptic.

Plan of Correction

Accept ([REDACTED] - 11/13/2024)

The first aid kit in the 2014 Chrysler Caravan was reviewed and checked by the Central Supply Purchasing Assistant to ensure that the vehicle had the first aid kit with the contents specified in 2600.96 and completed on 10/3/2024

171b5 - First Aid Kit (continued)

The transport driver will ensure that the listed items are in the first aid box prior to using the vehicle. The transport driver will initial and date the First Aid Check list each time the transport vehicle is used. The maintenance Supervisor and or designee will review the first aid kit and the check list weekly to ensure all items are accounted for in the First Aid kit.

The Maintenance Supervisor and/or designee will complete this QAA monitor weekly for four weeks, then monthly for three months and report the findings to the QAA Committee on a monthly basis.

If the QAA monitor reflects 100% compliance for three consecutive months, then the QAA monitor can be completed on a quarterly basis.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented (█) - 12/27/2024)

184a - Resident's Meds Labeled

13. 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 #2 is prescribed Ondansetron 4mg tablet, take 1 tablet by mouth every 6 hours as needed for nausea and vomiting; however, the pharmacy label indicated every 8 hours as needed.

Plan of Correction

Accept (█) - 11/13/2024)

Resident #2's Ondansetron 4 mg packages have been relabeled with : " Directions changed, refer to chart " as per our policy as of 10-28-2024, reflecting the change of order from prn Q8 hrs to prn Q 6 hrs per the physicians orders.

All prn stored medications will be evaluated for proper labels that match the current physician's orders. Medication that have the "direction change" label will be included in the properly labeled category for this process. All residents stored medication will be audited by 2 professional staff by 11-11-2024.

All nurses/ CMT's will be reeducated by the PCHA on the policy for relabeling medications when there is an order change . This education will be completed by 11-11-2024.

Two professionals will monthly monitor all prn medications for accurate labels that reflect the current physicians orders. The results of this audit will be validated by the PCHA.

Initial reporting to the QAA committee will be on Tuesday 11-12-2024. The ongoing monthly monitoring will be presented to the QAA committee monthly under the POC Agenda item by the PCHA.

Licensee's Proposed Overall Completion Date: 11/12/2024

184a - Resident's Meds Labeled (continued)

Implemented (█) - 12/27/2024)

185a - Implement Storage Procedures

14. 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 #3 is prescribed Novolog Flex pen 100 units/ml per sliding scale before meals and at bedtime. 150-199= 2 units, 200-249= 3 units, 250-299= 4 units, 300-349= 5 units, 350-400= 6 >400 give 8 units and call MD. However, on 10/2/24 at 7:56am the resident's glucometer reading of 369 was not documented on the resident's October 2024 medication administration record (MAR).

Plan of Correction

Accept (█) - 11/13/2024)

Investigation of the above identified that the BGCS of 369 was a high control, and the nurse followed with a new high and low control that is in evidence in the meter and on the control log. We speculate that the strip was a test and the meter had not been put in testing mode.

All professional staff will be re-educated on the process of documenting chemstrips in the MAR and controls in the control log, and the need for accuracy in this process. If there is a situation as above, the nurse should make a nurses note documenting this reading. They will also be educated on the use of the 24 hr monitoring process to be completed at change of shift nightly at 11pm. This education will be completed by 11-11-2024.

During shift change nightly at 11pm professional staff from off going shift and the oncoming shift will monitor and compare the glucometer readings with the MAR readings for each resident that requires chemstrips and insulin coverage per physician orders. One staff will read and document the glucometer readings and one staff will read and document the MAR readings, including times to validate accurate documentation for both. This constitutes a daily 24 hour look back period and these will be recorded on a worksheet which each staff member will sign for the area they observed. Any discrepancies will be identified to the PCHA for immediate investigation, problem solving and further counseling as indicated.

Initial reporting to the QAA committee will be on Tuesday 11-12-2024. The ongoing monthly monitoring will be presented to the QAA committee monthly under the POC Agenda item by the PCHA.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented (█) - 12/27/2024)

187d - Follow Prescriber's Orders

15. Requirements

2600.

187.d. The home shall follow the directions of the prescriber.

187d - Follow Prescriber's Orders (continued)

Description of Violation

Resident #3 is prescribed Novolog Flex pen 100 units/ml per sliding scale before meals and at bedtime as follows:

150-199= 2 units

200-249= 3 units

250-299= 4 units

300-349= 5 units

350-400= 6 units

>400 give 8 units and call provider

On 10/2/24 at 12:00 p.m. resident #3's blood sugar reading was 288 and the resident was administered 3 units. However, according to the prescriber's orders, the resident should have been administered 4 units.

On 10/2/24 at 9:00 p.m. resident #3's blood sugar reading was 277 and the resident was administered 5 units. However, according to the prescriber's orders, the resident should have been administered 4 units.

Plan of Correction

Accept (█ - 11/13/2024)

Both nurses that were involved in these errors have been re-educated on the need to be accurate when completing the task of providing coverage to diabetic residents in relation to the chemstrip reading. Employee counseling was completed on 10-28-2024.

All professional staff will be re-educated by the PCHA on the process of documenting chemstrips in the MAR and accurately identifying the ordered insulin dosage for administration and proper documentation of this by 11-11-2024.

During shift change nightly at 11pm professional staff from off going shift and the oncoming shift will monitor and compare the glucometer readings with the MAR readings for each resident that require chemstrips and insulin coverage per physician orders. One staff will read and document the glucometer readings and one staff will read and document the MAR readings along with including times to validate accurate documentation for both. This constitutes a daily 24 hour look back period and these will be recorded on a worksheet which each staff member will sign for the area they observed. Any discrepancies will be immediately investigated by the 2 staff members for problem solving, and this information relayed to the PCHA via report and an email for further follow up as needed.

Initial reporting to the QAA committee will be on Tuesday 11-12-2024. The ongoing monthly monitoring will be presented to the QAA committee monthly under the POC Agenda item by the PCHA.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented (█ - 12/27/2024)

224a - Preadmission Screen Form

16. 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.

224a - Preadmission Screen Form (continued)

Description of Violation

Resident #1 was admitted in the home on [redacted] however the resident preadmission screening was completed on [redacted]

Plan of Correction

Accept ([redacted] - 11/13/2024)

All resident's charts will be audited by the PCHA and a second professional for preadmission screenings within 30 days of admission and documented on a monitoring form for this purpose, completed by 11-11-2024.

Any residents that are assessed more than 30 days prior to admission will have a second preadmission assessment completed upon the admission date by the PCHA.

The PCHA, along with a second professional, will monthly review all active charts for proper completion of the preadmission assessment for each resident. This information will be reported to the QAA committee monthly under the POC monthly reporting agenda item.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented ([redacted] - 12/27/2024)

225a - Assessment 15 Days

17. Requirements

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.

Description of Violation

Resident #4 was admitted on [redacted]; however, the resident's assessment was not completed until [redacted]

Plan of Correction

Accept ([redacted] - 11/13/2024)

The PCAH will complete chart review for all current residents to ensure that all resident assessments have been completed in the 15 day window after admission, documenting any that do not meet the standard.

The PCHA, along with a second professional, will monthly review all active charts for proper completion of the current resident's assessment. This information will be reported to the QAA committee monthly under the POC monthly reporting agenda item.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented ([redacted] - 12/27/2024)

227g -Support Plan Signatures

18. Requirements

2600.

227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #5 participated in the development of [redacted] support plan on [redacted] However, the resident's signature on the support plan is not dated.

227g -Support Plan Signatures (continued)

Plan of Correction

Accept (█ - 11/13/2024)

Resident #5's support plan has been reviewed with █ signed and dated for 10-4-2024.

The PCAH will complete chart review for all current residents to ensure that all resident's support plans have been dated. Any that are found not dated will be reviewed with the resident and dated after that review. This will be completed by 11-11-2024.

The PCHA, along with a second professional, will monthly review all active charts for proper completion of the resident's signature on the support plan. This information will be reported to the QAA committee monthly under the POC monthly reporting agenda.

Licensee's Proposed Overall Completion Date: 11/12/2024

Implemented (█ - 12/27/2024)

233d - Electronic/Magnetic System

19. Requirements

2600.

233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

At 12:27 p.m., the magnetic lock on the emergency exit door leading to the exterior courtyard area of the secure dementia unit was not operable and did not lock the door.

Plan of Correction

Accept (█ - 11/13/2024)

The emergency exit door leading to the enclosed courtyard in the secured memory care dementia unit was locked due to an issue with parts and maintenance was not able to repair. The key to the emergency exit door leading to the courtyard was securely stored in the secured memory care unit in case of an emergency. Staff was able to access they key at any time.

The magnetic lock on the emergency exit door leading into the secured memory care dementia unit was replaced and repaired by maintenance on 10/21/2024

The Maintenance Supervisor and/or designee will monitor all doors with magnetic locks to ensure they are functioning properly.

The Maintenance Supervisor and/or designee will complete this QAA monitor weekly for four weeks then monthly for three months and report the findings to the QAA Committee on a monthly basis.

If the QAA monitor reflects 100% compliance for three consecutive months, then the QAA monitor can be completed on a quarterly basis.

Licensee's Proposed Overall Completion Date: 12/13/2024

Implemented (█ - 12/27/2024)