



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

APR 06 2017

Mr. Kirk Hawthorne,  
Administrator/COO  
Roman Catholic Diocese of Erie  
2250 Shenango Valley Freeway  
Hermitage, Pennsylvania 16148

RE: Saint John XXIII Home  
License #: 447600

Dear Mr. Hawthorne:

As a result of the Department of Human Services' annual licensing inspections on August 31, 2016 and September 1, 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.

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](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,

A handwritten signature in black ink, appearing to read "J. Rowe".

Jacqueline L. Rowe  
Director

Enclosure  
License Inspection Summary



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JAN 11 2017

Page 2 of 16

WEST REGIONAL FIELD OFFICE  
Human Services Licensing

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 58 Pa.Code §2800  
2800.17 - Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

2a. DESCRIPTION OF VIOLATION  
On 8/31/16, resident information was unlocked, unattended and accessible in the following areas:  
\* Multiple resident records, including residents #1, #2 and #3, were present in a metal filing cabinet in the activities room  
\* Multiple resident treatment records, including residents #4, #5 and #8, were in binders on a shelf at the secured dementia care unit's (SDCU) nurses station.

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.

1. Medical Records stored inappropriately/unsecured within the Activity Room storage closet have been removed and stored in a secure/locked location.
2. All Personal Care staff have been re-educated by Personal Care Administrator regarding proper storage of medical records and necessity to maintain a secure environment with all medical records, including those filed for storage.
3. Environmental rounds by Administrator revealed no further deficient practice of this nature. Weekly environmental rounds by Administrator related to Medical Record storage will be incorporated into the Quality Assurance Program.

Corrected 1/6/2017

Empty space for additional notes or attachments.

Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page) <i>Kirk Hawthorne</i>			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>KIRK HAWTHORNE ADMINISTRATOR / COO</i>			Date <i>01-11-2017</i>
<b>DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!</b>			
The above plan of correction is approved as of <u>1/20/17</u> (Date)		Plan of correction implementation status as of <u>1/20/17</u> (Date)	
The above plan of correction was approved by <u>[Signature]</u> (Initials)		<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <i>[checkmark]</i> <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented	

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WEST REGIONAL FIELD OFFICE  
Human Services Licensing Page 4 of 16

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa. Code §2800  
2800.65(f) - Training topics for the annual training for direct care staff persons shall include the following:  
(1) Medication self-administration training.  
(2) Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.  
(3) Care for residents with dementia and cognitive impairments.  
(4) Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.  
(5) Personal care services needs of the resident.  
(6) Safe management techniques.  
(7) Care for residents with mental illness or mental retardation, or both, if the population is served in the home.

2a. DESCRIPTION OF VIOLATION  
Direct care staff person A, hired on [redacted] 11, did not receive training on the following topics during the 2016 training year:  
\* Medication self-administration  
\* Instruction on meeting the needs as outlined in preadmission, assessment, medical evaluation and support plan  
Direct care staff person B, hired on [redacted] 12, did not receive training on the following topics during the 2016 training year:  
\* Medication self-administration  
\* Instruction on meeting the needs as outlined in preadmission, assessment, medical evaluation and support plan

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.

- Facility is a "non-self medication administration" facility as outlined in Addendum "D" of the Resident contract, thus, training for employees A & B did not occur. Facility will re-educate staff annually on facility policy of not permitting self administration of medications as a standard of practice.
- Training related to meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan was completed in December 2016 for all staff including Employee A & B. This training will be conducted annually for all staff by and documented accordingly.
- Staff training requirements and status of such will be reviewed with each Quality Assurance Meeting for all staff.

Completed: 1/6/2017

Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page) <i>Kirk Hawthorne</i>			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>KIRK HAWTHORNE - ADMINISTRATOR I COO</i>			Date <i>01-11-2017</i>
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WEST REGION FIELD OFFICE  
Human Services Licensing

Violation Report: 44760 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa. Code §2600  
2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:  
(1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.  
(2) Emergency preparedness procedures and recognition and response to crises and emergency situations.  
(3) Resident rights.  
(4) The Older Adult Protective Services Act (35 P. S. §§ 10226.101-10226.5102).  
(5) Falls and accident prevention.  
(6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION  
Direct care staff person A, hired on [redacted] 11, did not receive training on falls and accident prevention during the 2016 training year.  
Direct care staff person B, hired on [redacted] 12, did not receive training on falls and accident prevention during the 2016 training year.

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

1. Falls and accident prevention has been handled on a resident case by case basis/need and not documented/recorded specifically for staff training hours.
2. Personal Care Administrator will train all Personal Care staff related to Falls and Accident Prevention on 1/11/17 and 1/12/17. All staff will receive such training on an annual basis thereafter and training will be documented accordingly by Personal Care Administrator.
3. The status of annual training will be audited with each Quality Assurance meeting related to: 2600.65(e), 2600.65(1), and 2600.65(g) for all staff.

01-12-2017

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

Signature of Legal Entity Representative (Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *KIRK HAWTHORNE ADMINISTRATOR / COO*      Date *01-11-2017*

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Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
 PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 65 Pa.Code §2600  
 2600.82(o) - 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.

2a. DESCRIPTION OF VIOLATION  
 On 8/31/16, the following materials, with manufacturer's labels indicating that if swallowed get medical help or contact poison control center, were unlocked and accessible in the cabinet under the sink of the laundry room:  
 \* 1 gallon bottle of Array 3% bleach  
 \* 1-100 oz. container of Draft laundry detergent  
 \* 1 quart bottle of Comet  
 \* 1 bottle of Murphy Oil Soap

On 8/31/16, a 10 oz. bottle of Equate nail polish remover, approximately 1/8 full, with a manufacturer's label indicating, "Contact a physician or poison control if ingested" was unlocked and accessible in the activity room closet.

Not all residents of the home, including resident #7 and #8, have been assessed as capable of recognizing and using poisons safely.

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 items listed above were secured by Administrator at time of discovery and the Laundry personnel responsible for such was educated immediately by Administrator in presence of surveyor.
- Items are stored in a locked cabinet, which staff member failed to lock upon exiting the laundry room. Policy and procedure for securing all hazardous chemicals was reviewed with all personnel, including Laundry worker above by Personal Care Administrator.
- Random weekly audits of the Laundry room since discovery have revealed properly stored/secured chemicals within the Laundry area.
- Proper storage of hazardous chemicals will be incorporated into the Quality Assurance Program.

Corrected 8/31/2016

Immediately, A designated staff person shall inspect the home daily to ensure all poisonous materials are kept in an area that is locked. Documentation of the checks shall be kept. 1/20/17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	04/22/2015
Signature of Legal Entity Representative (Required on EVERY Page) <i>Kirk Hawthorne</i>		
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>KIRK HAWTHORNE - ADMINISTRATOR</i>		Date <i>01-11-2017</i>
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JAN 11 2017

WEST REGION FIELD OFFICE Page 7 of 16  
Human Services Licensing

Violation Report: 44760 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600

2600.87 - The home's rooms, hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

2a. DESCRIPTION OF VIOLATION

On 8/31/16, 2 lights were inoperable in the hallway near bedrooms #317 and #326, posing a safety hazard to residents.

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.

- Hallway lights near room #317 and #326 were replaced by Maintenance Director during survey and verified by surveyor. All remaining lights were functioning properly.
- Personal Care staff are aware to notify Maintenance upon discovery of a non-functioning light(s) as part of our Environmental Safety process.
- All staff are responsible to monitor proper functioning lighting as part of the Continuous Quality Improvement (CQI) process.
- It is impossible to avoid lights burning out, however, burnt out light bulbs are always replaced immediately.

Corrected 8/31/16

*Immediately: A designated staff person shall inspect all areas specified in 2600.87 at least monthly to ensure all areas are lighted. Any bulbs found to be inoperable shall immediately be replaced.*  
1/20/17

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

Signature of Legal Entity Representative (Required on EVERY Page) *Kiril Hawthorne*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *KIRIL HAWTHORNE - ADMINISTRATOR 1000*      Date *01-11-2017*

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The above plan of correction is approved as of 1/20/17 (Date)

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

Plan of correction implementation status as of 1/20/17 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *J*
- Partially Implemented - Inadequate Progress
- Not Implemented

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JAN 11 2017

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600  
2600.95 - Furniture and equipment must be in good repair, clean and free of hazards.

2a. DESCRIPTION OF VIOLATION  
On 8/31/16, the metal cover for the PTAC unit in the SDCU's activity room was completely off, exposing the inner mechanisms of the PTAC unit.  
On 8/31/16, the hand rail in the hallway next to the Roncalli Center was loose moved approximately 1/4".

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.

1. Metal cover on the PTAC unit facing the outside of the facility was replaced/secured at time of discovery. All other PTAC unit covers were found to be secure at time of survey as verified by surveyor.
2. Monthly Environmental Rounds by Maintenance Director has revealed no further deficient practice of this nature. All other furniture/equipment was found to be in good repair, clean and free of hazards. Environmental rounds by Maintenance Director will be incorporated into the Quality Assurance Program.
3. The handrail outside of Roncalli Center in question was secured at time of discovery by the Maintenance Director. Environmental rounds during survey by Maintenance Director revealed no further loose handrails. Monthly Environmental Rounds by Maintenance Director has revealed no further loose handrails since survey.
4. Personal Care and Maintenance Personnel have been re-educated regarding Maintaining furniture/equipment/handralls in good repair and free of hazards by their respective supervisors.

Corrected 8/31/2016.

Immediately: A designated staff person shall inspect the home, at least monthly, to ensure all furniture and equipment is in good repair, clean and free of hazards. 1/2017

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

Signature of Legal Entity Representative (Required on EVERY Page) KIRK Hawthorne

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) KIRK HALTHORNE - ADMINISTRATOR I COO Date 01-11-2017

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JAN 31 2017

WEST REGION FIELD OFFICE Page 9 of 16  
Human Services Licensing

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa. Code §2500  
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 8/31/16, the home's first aid kit did not include scissors.

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.

1. Scissors were added to the first aid kit upon discovery. A tear away security system has been implemented on the first aid kit to determine/signify use. Personal Care Administrator will assure that all necessary equipment (including scissors) are included within the first aid kit following each use.
2. The First Aid kit will be audited to contain all required items by the Personal Care Administrator with Each Quality Assurance meeting as well, *Audits of the first aid kit shall be at least monthly. 1/20/17*
3. All Personal Care staff have been re-educated regarding the content requirements of the First Aid kit by the Personal Care Administrator.

Corrected: 8/31/2016

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *KIRK HAWTHORNE - ADMINISTRATOR / COO*      Date *01-11-2017*

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JAN 13 2017

Violation Report: 44760 - 08/31/2016 - Garrigan, Laura		WEST REGION FIELD OFFICE Human Services Licensing	
PCH Name: SAINT JOHN XXIII HOME			
1. REGULATION 85 Pa.Code §2600 2600.101(j)(7) - Each resident shall have the following in the bedroom: An operable lamp or other source of lighting that can be turned on at bedside.			
2a. DESCRIPTION OF VIOLATION On 8/1/16, resident #9's bedside lamp was approximately 4' from the resident's bed and was unable to be turned off/on at bedside.			
3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.) <i>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.</i>			
<ol style="list-style-type: none"> <li>An operable bedside lamp has been placed directly next to resident (#9) bedside by Personal Care Administrator</li> <li>All residents have a bedside lamp as verified by Personal Care Administrator through room to room audit on 1/6/2017.</li> <li>All Personal Care staff have been re-educated regarding the 2600.101(7) requirements by the Personal Care Administrator.</li> <li>Bedside lighting will be audited by the Personal Care Administrator with each Quality Assurance meeting.</li> </ol> <p style="text-align: center;">Corrected 1/6/2017</p> <p><i>Immediately: A designated staff person shall inspect all resident bedrooms at least monthly to ensure each resident has an operable bedside lamp or other source of light within reach of their bed. 1/20/17</i></p>			
Repeat Violation: No	Date(s) of Previous Violation(s):		
Signature of Legal Entity Representative (Required on EVERY Page) <i>Kirk Hawthorne</i>			
Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>KIRK HAWTHORNE - ADMINISTRATOR / COD</i>			Date <i>01-11-2017</i>
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JAN 11 2017

WEST REGION FIELD OFFICE  
Human Services Licensing

Page 11 of 16

Violation Report: 44760 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 65 Pa. Code §2800  
2800.131(c) - A fire extinguisher with a minimum 2A-10BC rating shall be located in each kitchen. The kitchen extinguisher meets the requirements for one floor as required in § 2800.131(a).

2a. DESCRIPTION OF VIOLATION  
On 8/31/16, no fire extinguisher with a minimum 2A-10BC rating was present in the activity center's 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.

1. Since construction in 2001, the Activity Room Kitchen has been unchanged and has not had a fire extinguisher located next to the stove. On 8/31/2016, the Maintenance Director added a properly rated fire extinguisher directly next to the stove (photo attached) and verified by the surveyor..
2. The newly added fire extinguisher has been added to the monthly fire extinguisher checks/audits completed by the Maintenance personnel.
3. No other kitchen areas have been identified as lacking proper fire extinguisher(s).
4. Fire extinguisher audits will be incorporated into the Quality Assurance process.

Corrected 8/31/2016

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
(Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>KIRK HAWTHORNE - ADMINISTRATOR / COO</i>	Date <i>01-11-2017</i>
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JAN 13 2017

WEST REGIONAL OFFICE  
Human Services Licensing

Violation Report: 44760 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

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 home alternates their emergency exits during monthly fire drills; however, the fire drill records indicate the only exits used during the monthly fire drills from 8/21/16 through 8/9/16 were the "Personal care front entrance" and the "Special needs north exit."

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.

1. The facility is in compliance with 2600.132(c), including but not limited to the use of alternative exit routes during fire drills. However, the documentation (records) of such were incorrectly stated on the tracker form.
2. The Maintenance Director is responsible to conduct and properly document fire drills, times, exits used, etc. The Maintenance Director has been re-educated regarding the Fire Drill form completion including Exit Routes used by the Administrator.
3. Alternative Exits documentation use during Fire Drills has been properly recorded since discovery on 8/31/2016. (log attached).
4. Monthly fire drills and documentation of such is audited by the Administrator and incorporated into the Quality Assurance Program.

Corrected 1/8/2017

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative

(Required on EVERY Page)

KIRK HAWTHORNE

Printed Name and Title of Legal Entity Representative

(Required on EVERY Page)

KIRK HAWTHORNE - ADMINISTRATOR / COO

Date

01-11-2017

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

The above plan of correction is approved as of

1/20/17  
(Date)

Plan of correction implementation status as of

1/20/17  
(Date)

The above plan of correction was approved by

*[Signature]*  
(Initials)

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

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JAN 13 2017

WEST VIRGINIA HHS OFFICE  
Human Services Licensing

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa. Code §2600

2600.183(b) - Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

2a. DESCRIPTION OF VIOLATION

On 8/31/16, the following medications were unlocked and accessible in the upper right cabinet of the common laundry room:  
\* 2 bottles of Equate ibuprofen, 200 mg tablets  
\* 1 bottle of Aleve naproxen sodium, 220 mg tablets  
\* 1 bottle of Vitamin D3 6000 IU

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.

1. The laundry employee personal medications listed above were immediately secured by the Administrator at the time of discovery and the laundry personnel responsible for such was educated immediately by the Administrator that employee personal medications should not be stored in resident common areas.
2. All other medications were found to be properly stored/secured during Environmental Rounds during survey, as well as during monthly rounds by the Personal Care Administrator. Random weekly audits of the Laundry room since discovery have revealed no further medication storage violations. All Personal Care staff will be re-educated by their respective supervisor related to 2600.183(b).
3. Monthly Environmental safety round audits will be incorporated into the Quality Assurance Program.

Corrected: 8/31/2016

Immediately: A designated staff person shall inspect all areas where medications are stored, at least weekly, to ensure all prescription medications, OTC medications, CAM and syringes are kept in an area that is locked.

1/13/17

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) **KIRK HAWTHORNE - ADMINISTRATOR | COO**      Date **01-11-2017**

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

The above plan of correction is approved as of 1/20/17  
(Date)

Plan of correction implementation status as of 1/20/17  
(Date)

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

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

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JAN 17 2017

Violation Report: 44760 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 56 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

Resident #10 is prescribed, "Novolin R Insulin 100U/ML-Inject 6 units subcutaneously with lunch and dinner." However, the resident's August 2016 medication administration record (MAR) does not include the initials of the staff persons who administered the resident's Insulin at lunch on the following dates: 8/3/16, 8/9/16, 8/10/16, 8/11/16, 8/12/16, 8/26/16, 8/26/16, 8/27/16, 8/28/16 and 8/30/16.

Resident #10 is prescribed, "Novolog Flexpen Insulin 100U/ML daily at 7:30 a.m. per sliding scale as follows:

- 0 - 140 = 0 units
- 141 - 200 = 2 unit
- 201 - 260 = 4 units
- 261 - 300 = 6 units
- 301 - 360 = 8 units
- 361 - 400 = 10 units
- > 400 = call DR

On 8/9/16 at 7:30 a.m., resident #10's blood sugar reading was 169 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the site of the insulin administration.

On 8/11/16 at 7:30 a.m., resident #10's blood sugar reading was 179 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/12/16 at 7:30 a.m., resident #10's blood sugar reading was 164 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/16/16 at 7:30 a.m., resident #10's blood sugar reading was 194 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the site of the insulin administration.

On 8/21/16 at 7:30 a.m., resident #10's blood sugar reading was 168 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/22/16 at 7:30 a.m., resident #10's blood sugar reading was 143 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/23/16 at 7:30 a.m., resident #10's blood sugar reading was 169 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/24/16 at 7:30 a.m., resident #10's blood sugar reading was 183 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

On 8/30/16 at 7:30 a.m., resident #10's blood sugar reading was 191 and was administered 2 units of insulin; however, the resident's August 2016 MAR does not indicate the amount of insulin that was administered or the site of the insulin administration.

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.

(ATTACHED)

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

Signature of Legal Entity Representative  
(Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative  
(Required on EVERY Page) *KIRK HAWTHORNE - ADMINISTRATOR COO*

Date *01-11-2017*

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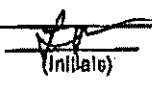
Plan of correction Implementation status as of *1/20/17*  
(Date)

- Fully Implemented
- Partially Implemented - Adequate Progress *[Signature]*

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JAN 11 2017

WEST REGIONAL FIELD OFFICE  
Human Services Licensing Page 15 of 16

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie PCH Name: SAINT JOHN XXIII HOME	
1. REGULATION 55 Pa.Code §2800 2800.187(b) - The information in § 2600.187(a)(13) and § 2800.187(a)(14) shall be recorded at the time the medication is administered.	
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

2600.187(b) PLAN OF CORRECTION:

1. Staff were re-educated regarding medication pass administration including but not limited to R#10 Insulin Administration, documentation of such including time, dosage, staff initials and site of administration by Personal Care Administrator and Nurse Medication pass instructor.
2. Training related to acceptable professional standards related to medication pass administration will be completed with all staff responsible to pass medications by Personal Care Administrator and annually thereafter. The training will include but not limited to the standards of 2600.187(a)(13) and 2600.187(a)(14).
3. Weekly and monthly audits of resident #10 Medication Administration record revealed no further deficient practice since training conducted 9/1/16. No further deficient practice related to Medication administration has been found.
4. Personal Care Administrator will audit R#10 Medication administration record monthly and 2 additional residents Medication administration records monthly related to acceptable professional standards and incorporate into the Quality Assurance Program.

Corrected: 1/6/2017

Kirk Hawthorne

KIRK HAWTHORNE - ADMINISTRATOR KOO 01/11/2017

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JAN 11 2017

Violation Report: 44780 - 08/31/2016 - Garrigan, Laurie  
PCH Name: SAINT JOHN XXIII HOME

WEST HESKON FIELD OFFICE  
Human Services Licensing

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

Resident #8 was admitted to the home's SDCU on [redacted] 16; however, the resident did not have a medication evaluation completed until 3/7/16.

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.

1. Resident #8 Medical Evaluation was completed 8 days post admission, which is non-compliant with 2600.231(b). Medical Evaluation was completed and resident is appropriate within the home's SDCU.
2. No further untimely Medical Evaluations were found at this time. All future Medical Evaluations will be conducted within 60 days prior to admission and monitored with EACH admission by the Personal Care Administrator. All Personal Care staff has been re-educated regarding the requirements of 2600.231(b) by the Personal Care Administrator.
3. Medical Evaluation timeliness audits, prior to each admission, completed by Personal Care administrator will be incorporated into the Quality Assurance Program.

Corrected: 1/6/2017

Immediately, the home shall develop and implement a system to ensure all residents admitted to the home's secured dementia care unit has a medical evaluation completed within 60 days prior to admission in accordance with 2600.231(b). All staff persons responsible for the admission process shall be educated on the new system. Documentation of the education shall be kept. *[Signature]*  
1/20/17

Repeat Violation: Yes      Date(s) of Previous Violation(s): 04/22/2015

Signature of Legal Entity Representative (Required on EVERY Page) *Kirk Hawthorne*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *KIRK HAWTHORNE - ADMINISTRATOR*      Date *01-11-2017*

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