pennsylvania
DEPARTMENT OF HUMAN SERVICES

DEC 2 9 2017

Mr. Kirk Hawthorne
Chief Executive Officer
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 September 21, 2017 and September 22, 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 JOHN XXIII HOME	License Number: 44760
Address: 2250 SHENANGO VALLEY FREEWAY, HERMITAGE, PA 16148	County: Mercer
Administrator: Linny Hardon	Region: WEST
Legal Entity Name: ROMAN CATHOLIC DIOCESE OF ERIE	
Legal Entity Address: 2250 SHENANGO VALLEY FREEWAY, HERMITAGE, PA 16148	

Certificate(s) of Occupancy

C-2 LP 01/28/2005 Labor and Industry	C-2 LP 05/16/2001 Labor and Industry	C-1 06/15/1971 Labor and Industry

Staffing Hours

Resident Support: 0	Total Daily Staff: 67	Waking Staff: 50
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced

Reason(s) for Inspection(s)
Renewal

On-Site Inspections Dates and Department Representatives On-Site
09/21/2017: Grace, Desmond; Flinner-Alman, Lisa
09/22/2017: Grace, Desmond; Flinner-Alman, Lisa

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: 98	Number of Residents who:
Number of Residents Served: 48	Receive Supplemental Security Income: 0
Secured Dementia Care Unit in Home: Yes	Are 60 Years of Age or Older: 48
Area: SDCU	Have Mental Illness: 0
Secured Dementia Unit Capacity, If Applicable: 32	Have an Intellectual Disability: 0
Number of Residents Served in Secured Dementia Care Unit, If applicable: 18	Have a Mobility Need: 19
Number of Current Hospice Residents: 0	Have a Physical Disability: 0
Number of Hospice Residents in past year: 0	

Kiara Hemingway

Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600

2600.65(a) - Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

(1) Evacuation procedures.
(2) Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
(3) The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
(4) Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
(5) The location and use of fire extinguishers.
(6) Smoke detectors and fire alarms.
(7) Telephone use and notification of emergency services.

2a. DESCRIPTION OF VIOLATION

Staff person B, hired 1/17/17, did not have initial training as related to smoking safety procedure, smoking policy and location of smoking area.

Staff person D, hired 8/1/17, did not have initial training as related to smoking safety procedure, smoking policy and location of smoking area.

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

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.65(a):

1 Orientaton checklist pertaining to 2600.65(a) requirements have been revised to include each of the 7 items in the regulation, including but not limited to smoking safety procedures, smoking policy and location of smoking areas.

2 Emergency preparedness 2600.65(a) requirements will be reviewed with all existing staff (including employee B & D) by the Personal Care Administrator by 12/13/17 and with all future personnel prior to or during the first work day.

3 The Human Resource Director will audit the Orientation training for all future employees related to 2600.65(a) and report such through the Quality Assurance Process. Human Resource Director will not permit employees to work without completion of such.

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

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

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

Date 11-15-2017

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

The above plan of correction is approved as of 11-29-17 (Date)

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

Plan of correction implementation status as of 11-29-17 (Date)

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

Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600

2600.65(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 service 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

Staff person A did not receive training in medication self-administration during the 2016 training year.

Staff person E did not receive training in medication self-administration during the 2016 training year.

Staff person C did not receive training in medication self-administration during the 2016 training year.

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.

2600.65(f)

1 Annual training checklist pertaining to 2600.65(f) has been revised to include each of the 7 items in the regulation, including but not limited to training in medication self-administration.

2 All Direct care staff (including employees A,C,E) will have "training in medication self-administration" by the Personal Care Administrator by 12/13/17.

3 The Human Resource Director will audit the Annual Training requirements of Direct Care Staff on a quarterly basis for timeliness and content completion (including Medication Self-Administration) and incorporate such into the Quality Assurance Process.

Immediately: The administrator shall review all staff training as part of the quality management review process to ensure staff persons have been provided the required training in accordance with regulation 2600.65(f).

11-29-17 g

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/31/2016		

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

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

Date 11-15-2017

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Violation Report: 44760 - 09/21/2017 - Graco, Desmond
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. §§ 10225.101-10225.5102).
(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

Staff person C did not recieve training in Older Adult Protective Services Act and falls/accident prevention during the 2016 training year.

Staff person E did not have training in Older Adult Protective Services Act and falls/accident prevention during the 2016 training year.

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.

2600.65(g)

1 Annual training checklist pertaining to 2600.65(g) has been revised to include each of the 6 items in the regulation, including but not limited to tainin related to Older Adults Protective Services Act and falls/accident prevention.

2 All Existing staff (including employees C & E) will have training related to "Older Adults Protective Services Act and Falls/Accident prevention by the Personal Care Administrator by 12/13/17.

3 The Human Resource Director will audit the Annual Training requirements for all staff on a quarterly for timeliness and content completion (including Older Adult Protective Services Act and falls/accident prevention) and incorportate such into the Quality Assurance Process.

Immediately: The administrator shall review all staff training as part of the quality management review process to ensure staff persons have been provided the required training in accordance with regulation 2600.65(g).

11-27-17

Repeat Violation: Yes	Date(s) of Previous Violation(s):	08/31/2016		

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 11-15-2017

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Violation Report: 44760 - 09/21/2017 - Graco, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600
2600.92 - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

2a. DESCRIPTION OF VIOLATION
On 9/21/17, the screen door to the internal courtyard on the chapel side on building had multiple holes and a bent lower frame which leaves a 1" wide by 2' long gap separating the screen from the door.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.92

1 A replacement screen door was ordered to replace the the damaged screen door at the internal courtyard within the Special Needs unit at time of identification. The door is currently on backorder and will be installed upon arrival by Maintenance Director. (by 12/13/17)

2 No further items; windows, doors or devices were found to be in poor repair during facility rounds by Administrator.

3 Administrator and Maintenance Director will make weekly environmental rounds to identify items in poor repair and resolve such upon identification.

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

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

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

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Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 65 Pa.Code §2600
2600.103(f) - Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

2a. DESCRIPTION OF VIOLATION
On 9/21/17 at 10:52 a.m., the Freezer temperature of the refrigerator/freezer of the activity room measured 8 degree Fahrenheit.

On 9/21/17 at 11:15 a.m., the special needs dining room freezer did not have a thermometer.

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.

2600.103(f)

1 The Thermometer within the Freezer in the Activity room was replaced at time of identification and and temperature was and continues to be below the 0 degree (F) requirement during survey. (9/21/17)

2 A thermometer was immediately added to the Freezer within the Special Needs dining room upon discovery of such. Freezer temperature were below the 0 degree (F) requirement. (9/21/17)

3 All refrigeration/freezer units throughout the facility have been checked with no further deficiencies found. Common area and kitchen refrigeration/freezer temperatures (including the two areas cited) will be monitored for thermometer placement and proper Temperatures by the Dietary Manager on a weekly basis (freezer and refrigerator temperatures will be documented).

4 Discrepencies in temperature will immediately be reported to the Maintenance Director for resolution.

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

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(Required on EVERY Page) KIRK HAWTHORNE - ADMINISTRATOR

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Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

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.

2a. DESCRIPTION OF VIOLATION

Resident #3 is ordered 2 sprays of 50mcg of Fluticasone Propionate 0.05% to each nostril daily as needed. However, the medication label indicates 2 sprays to each nostril daily.

Resident #5 is ordered Quetiapine Fumarate 50mg by mouth daily at bedtime. However, the medication label indicates 1½ tablets for 75mg by mouth daily.

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.

2600.184(a)

1 Resident (#3) Fluticansone Propionate order has been clarified and physician order, MAR and medication label match. Resident (#6) QuetiapineFumarate order has been clarified and physician order, MAR and medication label match.

2 All Direct Care Staff will be re-educated on the requirements and standards of 2600.184(a) by the Personal Care Administrator by 12/13/17.

3 Medication orders and medication labels will be audited for completeness and accuracy by the LPN charge nurse during monthly changeover; including but not limited to Resident name, medication name, date of prescription, dosage, instructions and name and title of prescriber.

4 Personal Care Administrator will audit the physician orders, Medication labels and MAR of 3 residents weekly for compliance with 2600.184(a). Finding of the audit will determine additional training needs. Finding of the audit will be incorporated into the Quality Assurance Process.

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

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

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

Date 11-15-2017

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- ☐ Not Implemented

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.

2a. DESCRIPTION OF VIOLATION
On 9/22/17 at 1:38pm, resident #3 glucometer not calibrated with current date and time. The resident's glucometer indicated 2/11/17 at 7:29 p.m.

Resident #6 is ordered blood glucose checks twice daily, on 9/17/17 at 6:00 a.m. staff person G did not document the glucose reading of 211mg/dl.

Resident #7 is ordered blood glucose checks three times per day, on 9/22/17 at 11:30 a.m. staff person H did not document glucometer reading of 230mg/dl.

Resident #8 is ordered blood pressure check twice a week on Mondays and Thursdays, on 9/14/17 the staff did not document the resident's blood pressure reading.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

2600.185(a)

1 The entire Glucometer policy, procedure, process and device use was revised at time of survey/ discovery. At time of survey, new Glucometers were purchased by the facility for each resident in need of such. Each new Glucometer was calibrated to accurately reflect date/time.

2 All Direct care staff were educated by the Personal Care Administrator regarding the Glucometer policy, procedure, process, as well as, following of physician orders.(9/22/17)

3 All Direct Care staff will be re-educated by the Personal Care Administator related to Glucometer use and following of physician orders related to Blood Pressure checks and documentation of such by 12/13/17.

4 Daily, weekly and monthly auditing of the Glucometer readings and MAR documentation according to physician order have found compliance with the revised process/orders for all residents (including residents 3, 6, 7) ordered Glucometer checks and blood pressure checks (resident 8) by Personal Care Administrator

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

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

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

Date 11-15-2017

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- ☐ Fully Implemented
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- ☐ Not Implemented

Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600
2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION
Resident #3 is ordered Salonpas Lidocaine patch X 1 patch twice a day to affected area (back, hip, and leg) as needed. On 9/21/17 at 6:30 p.m. the resident requested the medication. However, the medication was not available in the home for administration and not administered.

Resident #7 is ordered blood glucose checks three times per day. However, on 9/22/17 at 7:30 a.m. staff member H did not complete the resident's blood glucose checks as ordered.

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.

2600.187(d)

1 All Direct Care staff will be re-educated by the Personal Care Administrator related to 2600.187(d) "Following of Physician/Prescriber orders", including but not limited to medication administration, Glucometer/Blood Glucose checks and Blood Pressure checks and documentation of such in the Medical Record.

2 All Direct Care staff will also be re-educated by the Personal Care Administrator by 12/13/17, related to the process and documentation related to securing medications which are supplied by outside pharmacy and delivered by residents family member.

3 Personal Care Administrator will audit the medication availability and medications administered according to physician orders for 3 residents weekly to determine future training needs. The findings of the audits will be incorporated into the Quality Assurance Process.

4 Resident (3) had Lidocaine patch orders that family delivers. Family was notified of the need for medication but had not yet delivered. Facility lacked documentation to verify such. The notification and documentation of such has been revised.

5 Resident (7) missed Glucose check on 9/22/17 by employee (H) was resolved with the revised Glucometer policy and training provided by Personal Care Administrator on 9/22/17.

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

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

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

Date 11-15-2017

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The above plan of correction is approved as of 11-29-17 (Date)

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- ☐ Fully Implemented
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Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

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

Resident #2's assessment, dated 8/14/17, does not include the resident's diagnosis of dementia which is indicated on the residents medical evaluation form dated 8/3/17.

Resident #4's assessment, completed on 9/21/17, does not assess the resident's needs for agitation or the ability to avoid poisons. Those sections were blank.

Resident #5's assessment, completed on 6/18/17, does not assess the resident's needs for toileting and the ability to avoid poison. These sections were blank.

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.

2600.225©

1 Resident (2) assessment has been updated to properly reflect the diagnosis of dementia.

2 Resident (4) assessment has been updated to properly reflect residents agitation and ability to avoid poisons.

3 Resident (5) assessment has been updated to properly reflect residents toileting needs and ability to avoid poisons.

4 All Direct Care staff will be reeducated by the Personal Care Administrator by 12/13/17 related to 2600.225c, including but not limited to diagnosis inclusion, agitation/irritability, ability to avoid poisons and that the assessment should be all inclusive and sections should not be left blank

5 Personal Care Administrator will audit the contents of the Assessment for 3 residents weekly for accuracy and completeness. Results will determine additional training needs. Results will also be incorporated into the Quality Assurance Process.

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

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

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

Date 11-15-2017

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

Plan of correction implementation status as of 11-29-17 (Date)

- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Violation Report: 44760 - 09/21/2017 - Grace, Desmond
PCH Name: SAINT JOHN XXIII HOME

1. REGULATION 55 Pa.Code §2600
2600.227(c) - The support plan shall be revised within 30 days upon completion of the annual assessment or upon changes in the resident's needs as indicated on the current assessment.

2a. DESCRIPTION OF VIOLATION
Resident #5 support plan, completed on 5/18/17, indicates the resident has a minimal problem with irritability and a moderate problem with long term memory. However, there is no plan to meet the resident's needs. These sections were blank.

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.

2600.227©

1 The Support Plan for Resident (5) has been updated to include a plan/approaches related to residents irritability and moderate long term memory issues.

2 All Direct Care staff will be re-educated by the Personal care Administrator by 12/13/17 related to 2600.227c, including but not limited to development of a complete comprehensive plan to meet the residents needs (no blank sections).

3 Personal Care Administrator will audit the contents of the Support Plan for 3 residents weekly for accuracy and comleteness. Results will determine additional training needs. Results will also be incorporated into the Qaulity Assurance Process.

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

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

Printed Name and Title of Legal Entity Representative
(Required on EVERY Page) Kirk Hawthorne - Administrator

Date 11-15-2017

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

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- ☐ Fully Implemented
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