



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

NOV 14 2018

Mr. Joshua F. Bashore-Steury, LSW, PCHA  
Director of Personal Care  
The Mennonite Home  
1520 Harrisburg Pike  
Lancaster, Pennsylvania 17601

RE: Mennonite Home  
Susquehanna 1-3 Floors  
Juniata 1-4 Floors  
Certificate #: 321780

Dear Mr. Bashore-Steury:

As a result of the Department's Bureau of Human Services Licensing annual inspection on September 5 and 6, 2018 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 that reads 'J. Rowe'.

Jacqueline L. Rowe  
Director

Enclosure  
License Inspection Summary



Violation Report: 32178 - 09/05/2018 - Comstock, Kellie  
 PCH Name: MENNONITE HOME SUSQ1 3 4 FL JUNIATA1 4 FL CONESTOGA 1 FL

**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**  
 Direct Care Staff Person B did not receive training in medication self-administration during training year 2017.

**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.*

Please see Appendix A, Page 2A of 5 -GE

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *J - D - S, PLHA, Lrw*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Joshua Dasher - Steury, Director* Date *10/24/18*

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

The above plan of correction is approved as of <u>11/5/18</u> (Date)  The above plan of correction was approved by <u>GE</u> (Initials)	Plan of correction implementation status as of <u>11/5/18</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
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Appendix A

Plan of Correction for 2600.65(f)

Staff records have been reviewed to ensure that Direct Care Staff Person B received training in resident self-administration of medication for this calendar year. If any additional training is found to be necessary as part of the review of staff records, it will be completed by the end of this calendar year.

The results of the staff training record reviews will be included during the home's periodic quality management reviews, to ensure that all staff receive the required training each year. - GE

J. - [Signature], DCHA, LSC

Joshua Basbone-Stevenson, Director 10/24/14

Violation Report: 32178 - 09/05/2018 - Comstock, Kellie  
 PCH Name: MENNONITE HOME SUSQ1 3 4 FL JUNIATA1 4 FL CONESTOGA 1 FL

**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**

Ancillary Staff Person A did not receive fire safety training by a fire safety expert during training year 2017.

**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.*

Please see Appendix B. Page 3 A of 5 - GE

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *J - D - D - O, PLHA, LSW*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Joshua Barhore - Steury, Director* Date *10/24/18*

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

The above plan of correction is approved as of <u>11/5/18</u> (Date)	Plan of correction implementation status as of <u>11/5/18</u> (Date)
The above plan of correction was approved by <u>GE</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Appendix B

Plan of Correction for 2600.65(g)

Fire training by a fire safety expert is taking place in October 2018. The expectations for all ancillary staff to attend the fire safety training by a fire safety expert have been reviewed. Attendance sheets will be utilized to ensure all necessary staff attend the fire safety training.

Fire safety training will be addressed at the home's periodic quality management reviews. - GE

9-3-18, PCWA, LSW  
10/24/18  
Joshua Barlow - Stearns

Violation Report: 32178 - 09/05/2018 - Comstock, Kellie  
 PCH Name: MENNONITE HOME SUSQ1 3 4 FL JUNIATA1 4 FL CONESTOGA 1 FL

**1. REGULATION 55 Pa.Code §2600**  
 2600.121(a) - Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

**2a. DESCRIPTION OF VIOLATION**  
 The exit doors at Bedrooms 116 and 115 and Bedrooms 122 and 121 in the secured dementia care unit lead to outside of the building. These doors are not programmed to unlock with the visitor key fobs.

**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.

Please see Appendix C. Page 4A of 5 - GE

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *J - B - Dy, DLHA, LSW*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Joshua Barber - Steury, Director</i>	Date <i>10/24/18</i>
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 (Date)

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

Plan of correction implementation status as of 11/5/18  
 (Date)

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

Appendix C

Plan of Correction for 2600.121(a)

Goal date: January 1<sup>st</sup>, 2019

Plan of Correction: A process has been established to direct visitors to a predetermined site for the option of obtaining a visitors badge that will provide visitors access out all exits for Landis Run. Once off of Landis Run, it will be the responsibility of the visitor to return the visitor badge. Appropriate signage will be added in accordance with the recommendations.

With the new visitor badge process, all visitors and staff will have access to the identified exits at the ends of the hallway. - GE

Josh Bashore - Stearns, PLHA, LSU

10/24/18

Josh Bashore - Stearns, Director

Violation Report: 32178 - 09/05/2018 - Comstock, Kellie  
 PCH Name: MENNONITE HOME SUSQ1 3 4 FL JUNIATA1 4 FL CONESTOGA 1 FL

**1. REGULATION 55 Pa.Code §2600**

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

**2a. DESCRIPTION OF VIOLATION**

Resident #1 was admitted to the Secure Dementia Care Unit (SDCU) on 4/11/18. The resident's cognitive pre-admission screening was dated 3/9/18.

Resident #2 was admitted to the SDCU on 2/13/18. The resident's cognitive pre-admission screening did not include a diagnosis of Alzheimer's or other dementia.

**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.*

Please see Appendix D. Page 5A of 5 - GE

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) *Jim Bachner, DCHA, LICW*

Printed Name and Title of Legal Entity Representative  
 (Required on EVERY Page) *Joshua Bashore-Stevenson, Director* Date *10/24/18*

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 (Date)

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- Partially Implemented - Inadequate Progress
- Not Implemented

Appendix D

Plan of Correction for 2600.231(c)

The Prescreen form will be completed according to the requirements of Section IV. The Director of Personal Care, Designee, Night Shift Clinical Coordinator, and the Night Shift Assistant Clinical Coordinator have been re-educated on the requirements for Section IV of the Prescreen form and the process of auditing the completed Prescreen forms.

In reviewing the report for Resident #1 and Resident # 2 on Landis Run, the following was found:

1. For Resident # 1, the date 3/9/18 was the date the resident was last seen in the office. The time and date stamps from the fax show section IV of the form was completed within the regulatory 72 hour time frame prior to this resident's admission.
2. For Resident # 2, the diagnoses was missing from the diagnoses box. However, the attached dictated note from the CRNP clearly lists dementia as this resident's primary diagnoses making him appropriate for the secured memory support unit. This meets the intention of the regulation.

John Doolittle, PEHA, LSU

10/24/18

Justine Bashore-Stearns, Director