



October 10, 2019

Ms. Shannon Gerst
Administrator
The Arbors at St. Barnabas, Inc.
85 Charity Place
Valencia, Pennsylvania 16059

RE: The Arbors at St. Barnabas
Certificate #: 423090

Dear Ms. Gerst:

As a result of the Department's Bureau of Human Services Licensing annual inspection on July 30, 2019, of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report 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,

A handwritten signature in black ink, appearing to read "Kevin Hancock".

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

RECEIVED

SEPT 4 2019

WEST REGION FIELD OFFICE
Human Services Licensing

Violation Report

Facility Information

Name: *THE ARBORS AT ST BARNABAS*

License Number: 42309

Address: *85 CHARITY PLACE, VALENCIA, PA 16059*

County: *BUTLER*

Region: *WESTERN*

Administrator

Name: *Shannon Gerst*

Phone: *7246254000*

Email: *SGERST@STBARNABASHEALTHSYSTEM.COM*

Legal Entity

Name: *THE ARBORS AT ST BARNABAS INC*

Address: *85 CHARITY PLACE, VALENCIA, PA, 16059*

Certificate(s) of Occupancy

Type: *I-1*

Date: *06/04/2010*

Issued By: *Adams Township*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *95*

Waking Staff: *71*

Inspection

Type: *Full*

BHA Docket #:

Notice: *Unannounced*

Reason: *Renewal*

Inspection Dates and Department Representative

07/30/2019 - On-Site: Josh Hoover, Laurie Garrigan, Lauren Spagna

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *182*

Residents Served: *73*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *73*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *2*

Have Mobility Need: *22*

Have Physical Disability: *0*

41d - Rights/Complaint Procedures

Regulations

2600.

41.d. A copy of the resident's rights and complaint procedures shall be given to the resident and, if applicable, the resident's designated person upon admission.

Description of Violation

The copy of resident's rights provided to resident #1 in the resident-home contract, dated 6/28/2000, does not include numerous resident's rights, including the following:

- A resident shall have access to a telephone in the home to make calls in privacy. Non-toll calls shall be without charge to the resident
- A resident shall receive assistance in accessing health services.
- A resident shall receive assistance in obtaining and keeping clean, seasonal clothing. A resident's clothing may not be shared with other residents.
- A resident and the resident's designated person, and other individuals upon the resident's written approval shall have the right to access, review and request corrections to the resident's record.

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 home shall provide a copy of resident's rights upon admission. Resident #1 was provided with a most recent copy of resident's rights. An audit of all resident contracts was completed to ensure all updated resident's rights have been included.

Staff will be educated by staff development or designee on regulation 2600.41.d (a copy of the resident's rights and complaint procedures shall be given to resident and designated person). All education will be completed by September 18, 2019. The administrator and/or designee will continue to monitor that all contracts have an updated list of resident's rights.

Legal Entity Representative

Shannon Gerst, RN PCH-A
Signature

Shannon Gerst, RN PCH-A
Printed Name and Title

9.4.19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of
(Date)

9/5/19
(Date)

Plan of correction implementation status as of
(Date)

9/5/19
(Date)

The above plan of correction was approved by

(Handwritten initials)
(Initials)

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

85a - Sanitary Conditions

Regulations

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

There were no paper towels, mechanical air blower, individual cloth towels or other means of sanitary hand-drying in the 1st floor spa room.

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.)

On 7/30/2019 upon being notified that the 1st floor spa room did not have paper towels, they were immediately replaced.

All nursing and housekeeping staff will be educated by staff development or designee on regulation 2600.85.a (sanitary conditions shall be maintained). All education will be completed by September 18, 2019.

Immediately, then at least weekly, the director of housekeeping or designated staff person will inspect the home to ensure means of sanitary hand-drying items are available and replaced as needed.

Legal Entity Representative

Shannon Gerst, RN PCH-A
Signature

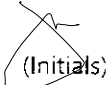
Shannon Gerst, RN PCH-A
Printed Name and Title

9.4.19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)

The above plan of correction was approved by 
(Initials)

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

102i - Soap Dispenser

Regulations

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

There was no soap available in either common bathroom on the 1st floor.

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.)

On 7/30/2019 upon being notified that the bathroom on the 1st floor did not have a working soap dispenser, the batteries were replaced immediately.

All nursing and housekeeping staff will be educated by staff development or designee on regulation 2600.102.i (a dispenser with soap shall be provided within reach of each bathroom sink). All education will be completed by September 18, 2019.

immediately, then at least weekly, the director of housekeeping or designated staff person will inspect the home to ensure means of a working soap dispenser is available.

Legal Entity Representative

Shannon Gerst, RN PCH-A
Signature

Shannon Gerst, RN PCH-A
Printed Name and Title

9.4.19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)

The above plan of correction was approved by
(Initials)

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

103f - Refrigerator/Freezer Temps

Regulations

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.

Description of Violation

The thermometer in the freezer in the 2nd floor dining area was broken.

There was an 18-ounce jar of blackberry jam with a label indicating "refrigerate after opening" in a cabinet in the 2nd floor dining area.

REPEAT VIOLATION: 07/24/2018

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.)

On 7/30/2019 upon being notified that the thermometer in the freezer in the 2nd floor dining area was broken, it was immediately replaced and the 18 oz. jar of blackberry jam was disposed of.

The nursing and food service staff will be educated by staff development or designee on regulation 2600.103.f (food requiring refrigeration shall be stored at or below 40°F. Thermometers are required in refrigerators and freezers). All education will be completed by September 18, 2019.

Immediately, and then at least weekly thereafter, the administrator or designated staff person will inspect the home to ensure all refrigerators and freezers have working thermometers and all food requiring refrigeration is not left out.

Legal Entity Representative

Shannon Gerst, RN, PCH-A
Signature

Shannon Gerst, RN PCH-A
Printed Name and Title

9.4.19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)

The above plan of correction was approved by

(Handwritten initials)
(Initials)

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

187c - Refusal of Medication

Regulations

2600.

187.c. If a resident refuses to take a prescribed medication, the refusal shall be documented in the resident's record and on the medication record. The refusal shall be reported to the prescriber within 24 hours, unless otherwise instructed by the prescriber. Subsequent refusals to take a prescribed medication shall be reported as required by the prescriber.

Description of Violation

Resident #2 refused the prescribed medication Phenytoin Sodium at 8:00a.m. from 7/2/2019 to 7/10/2019 and from 7/14/2019 to 7/18/2019, and at 9:00p.m. from 7/6/2019-7/27/2019. Resident #2's physician was not notified of these refusals. The home has a missed medication notification procedure for resident #2, signed by the resident's physician, indicating "I do not need notified each time the resident refuses the above medication/treatment(s)," however no medications or treatments are indicated on the form.

Resident #3 refused his prescribed TED hose from 7/2/2019 to 7/5/2019, 7/8/2019 to 7/21/2019, and 7/23/2019 to 7/28/2019. Also, resident #3 refused his prescribed medication Polyethylene Glycol on 7/8/2019 to 7/12/2019 and 7/14/2019 to 7/19/2019. The home has a missed medication notification procedure for resident #3, signed by the resident's physician, indicating "I do not need notified each time the resident refuses medications/treatments unless longer than three days." Resident #3's physician was not notified of these refusals when they exceeded 3 days.

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.)

An updated notification of refusal of medications completed by the provider was obtained for resident #2. After the discussion with the resident regarding the repeated refusals of his stockings, the physician order was obtained to discontinue the stocking.

An audit will be completed of all resident refusal forms to ensure we are following physician recommendations. A quality assurance check will be implemented weekly for one month, bi-monthly for one month, and monthly thereafter. Five residents will be evaluated per audit to ensure we are following recommendations by the physician of the resident refusal of medications. (continued on separate paper)

Legal Entity Representative

Continued - See page 6A of 8

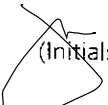
Shannon Gerst, RN PCH-A
Signature

Shannon Gerst, RN PCH-A 9.4.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)


The above plan of correction was approved by 
(Initials)

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

(continued POC for 2600.187.c)

All nursing staff will be educated by staff development or designee on regulation 2600.187.c (if a resident refuses to take a prescribed medication, the refusal shall be documented and the refusal shall be prescribed within 24 hours). All education will be completed by September 18, 2019.

Shannon Gerst, RN PCH-A *Shannon Gerst, RN PCH-A*
9.4.19

 9/5/19

191 - Resident Right to Refuse

Regulations

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Residents #1 and #2 have not been educated on the resident's right to question or refuse medication if the resident believes that there may be a medication error.

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.)

Resident #1 and #2 have been educated on the resident right to question or refuse medication if they believe there may be a medication error. This documentation of resident education will be kept in the resident's record.

All nursing staff will be educated by staff development or designee on regulation 2600.191 (resident education). This education will be completed by September 18, 2019.

Legal Entity Representative

Shannon Gerst, RN PCH-A
Signature

Shannon Gerst, RN PCH-A 9.4.19
Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)

The above plan of correction was approved by

(Handwritten initials)
(Initials)

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

226a - Mobility Assessment

Regulations

2600.

226.a. The resident shall be assessed for mobility needs as part of the resident's assessment.

Description of Violation

The assessment for resident #4, dated 6/5/2019, indicates that the resident has minimal mobility needs; however, the assessment also indicates that the resident has a diagnosis of dementia, requires extensive supervision, and has severe problems with orientation to time, place, and person, judgement, communication of needs, and short-term memory, as well as moderate problems with understanding instructions. Also, the preadmission screening form for this resident, dated 5/13/2019, indicates that the resident is immobile and indicates "cognitive loss" for reason for leaving current residence.

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.)

Although resident #4 assessment indicated she requires extensive supervision, has severe problems with orientation, communication of needs and short term memory, resident #4 has the ability and cognitive strength to follow physical prompts and cues provided by staff to evacuate in the event of an emergency.

Staff have been educated and continue to be educated on providing both verbal and physical cues on evacuation procedures to all residents, including those with cognitive deficits.

A quality assurance check will be implemented weekly for one month, bi-monthly for one month, and monthly thereafter. Five residents assessments and DME's will be evaluated to ensure resident's safety and well-being.

Legal Entity Representative

Shannon Gerst, RN PCH-A
Signature

Shannon Gerst, RN PCH-A
Printed Name and Title

9.4.19
Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 9/5/19
(Date)

Plan of correction implementation status as of 9/5/19
(Date)

The above plan of correction was approved by

(Signature)
(Initials)

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