pennsylvania
DEPARTMENT OF HUMAN SERVICES

November 20, 2019

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's Bureau of Human Services Licensing annual inspection on September 11, 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,

Kevin Hancock
Deputy Secretary
Office of Long Term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *SAINT JOHN XXIII HOME*
License Number: *44760*
Address: *2250 SHENANGO VALLEY FREEWAY,, HERMITAGE, PA 16148*
County: *MERCER*
Region: *WESTERN*

Administrator

Name: *Kirk Hawthorne*
Phone: *7249813200*
Email: *KLHAWTHORNE@STJOHN23HOME.ORG*

Legal Entity

Name: *ROMAN CATHOLIC DIOCESE OF ERIE*
Address: *2250 SHENANGO VALLEY FREEWAY, HERMITAGE, PA, 16148*

Certificate(s) of Occupancy

Type: *C-2 LP*	Date: *01/28/2005*	Issued By: *Labor and Industry*
Type: *C-2 LP*	Date: *05/16/2001*	Issued By: *Labor and Industry*
Type: *C-1*	Date: *05/15/1971*	Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0*
Total Daily Staff: *65*
Waking Staff: *49*

Inspection

Type: *Full*
BHA Docket #:
Notice: *Unannounced*
Reason: *Renewal*

Inspection Dates and Department Representative

09/11/2019 - On-Site: Laurie Garrigan, Lori Gillette

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98*
Residents Served: *44*

Secured Dementia Care Unit

In Home: *Yes*
Area: *Special Needs Unit*
Capacity: *32*
Residents Served: *21*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *44*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *21*
Have Physical Disability: *0*

103e - Left Overs

Regulations

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

There was an opened, undated plastic Ziploc bag of vegan meatballs in the main kitchen freezer.

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 opened, undated package of vegan meatballs was discarded by Dietary Manager on 9/11/19 upon discovery. No further food storage/labeling issues were identified at time of survey.

Dietary Manager has re-educated all Dietary Personnel regarding proper food storage/labeling, including but not limited to 2600.103.e

Dietary Manager (or designee) will monitor/audit the proper storage and labeling of food within the Main Kitchen on a daily basis.

The Food Storage/Labeling audits above, will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

Completion: 09/11/2019

Legal Entity Representative

Kirk Hawthorne NHA | CEO
Signature

Kirk Hawthorne, Administrator /CEO — 10/02/19
Printed Name and Title — Date

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The above plan of correction is approved as of 10/24/19 (Date)

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

Plan of correction implementation status as of 10/24/19 (Date)

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

105g - Lint Removal and Duct Cleaning

Regulations

2600.

105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 9/11/19, there was an approximate 1/4-inch accumulation of lint in the lint trap of dryer #3. There were no clothes in the dryer at the time.

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.)

Upon discovery (9/11/19), the lint trap of dryer #3 was cleaned by the Maintenance Director during survey rounds. No further lint/lint trap issues were identified at time of survey.

Nursing, Environmental Service and Maintenance staff have been re-educated by their respective department Manager related to 2600.105.g standards and the facility policy, procedure and expectations related to such.

Environmental Services Manager (or designee) will monitor/audit the lint traps of each dryer throughout the facility on a daily basis (varied times) to ensure compliance and proper cleaning is followed.

The daily Lint Trap audits above, will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

Completion : 09/11/19

Legal Entity Representative

Kirk Hawthorne Administrator/CEO
Signature

Kirk Hawthorne NHA/CEO — 10/02/19
Printed Name and Title — Date
KIRK HAWTHORNE

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132b - Safety Inspection/Fire Drill

Regulations

2600.
132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The current fire safety inspection and fire drill conducted by a fire safety expert were completed on 6/20/19. However, the previous fire safety inspection and fire drill were completed on 4/18/18.

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.)

Local Hermitage Fire Chief/Fire Safety expert was not available to complete the annual training until June 2019.
The 2020 Annual Fire Safety inspection and fire drill will be held prior to 6/20/2020.
No further violations of this nature were identified at time of survey.
The Annual Fire Safety Inspection and Fire drill will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

The administrator or designated staff person will monitor the fire drill record to ensure that a fire safety inspection and fire drill are conducted by a fire safety expert annually. 10/24/19

Completion date: 09/11/2019

Legal Entity Representative

Kirk Hawthorne Administrator/CEO
Signature

Kirk Hawthorne - Administrator/CEO 10/02/19
Printed Name and Title Date

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184a - Labeling OTC/CAM

Regulations

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 was prescribed Loperamide HCL 2 mg capsules-take 1 capsule by mouth 3 times a day as needed. However, the prescription label on the medication indicates Loperamide HCL 2 mg capsules- take 1 capsule by mouth 4 times a day as needed.

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.)

At time of discovery, Resident #1 Loperamide order was verified with Resident #1 attending physcian signed order dated 9/1/2019 (Loperamide HCL 2mg Cap 3x daily as needed). Medication Change Label was immediately added to the Medication Card by LPN, to ensure that medication is properly labeled consistent with the Physician Order. Facility wide audit of Medication orders/Labels matching, completed by Personal Care Manager revealed no additional errors of this nature (2600.184.a).

Personal Care Manager will re-educate all nursing staff related to the requirements of 2600.184.a, including but not limited to physician order(s) and medication container labels matching.

Personal Care Manager will audit the physician orders matching medication labels for 4 residents weekly for 3 months to ensure compliance with 2600.184.a. Resident selection will be on a rotational basis so all residents are reviewed.

The above weekly audits will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

Completed 09/11/2019

Legal Entity Representative

Kirk Hawthorne NHA/CEO — Signature

KIRK HAWTHORNE - ADMINISTRATOR/CEO — Printed Name and Title

10/31/2019 — Date

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187b - Date/Time of Medication Admin.

Regulations

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Eliquis 2.5 mg tablet-take 1 tablet by mouth 2 times daily. Resident #2's September 2019 medication administration record (MAR) does not include the initials of the staff person who administered the medication on 9/6/19 at 8:00 p.m.

Repeat Violation: 9/18/2018

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.)

Licensed Practical Nurse (LPN) responsible for the Medication administration documentation error on the MAR for resident #2 on 9/6/2019 verified that the Eliquis was administered as ordered and corrected the MAR on 9/11/19. Facility wide audit of MAR documentation completed by Personal Care Manager revealed additional errors (holes), of a similar nature, which will be rectified through education (below).

Personal Care Manager will re-educate all nursing staff related to the requirements of 2600.187.b, including but not limited to proper documentation standards during medication administration. Employee who made the identified error related to resident #2 on 9/6/19 has received individual education related to such as well.

Personal Care Manager will audit the Medication Administration Record (MAR) for 4 residents weekly for 3 months to ensure compliance with 2600.187.b. Resident selection will be on a rotational basis so all residents are reviewed.

The above weekly audits will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

Completed: 09/11/2019

Legal Entity Representative

Kirk Hawthorne

Signature

Kirk Hawthorne - Administration | CEO — 10/07/2019

Printed Name and Title — Date

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227h - Support Plan Refuse Sign

Regulations

2600.
227.h. If a resident or designated person is unable or chooses not to sign the support plan, a notation of inability or refusal to sign shall be documented.

Description of Violation

Resident #3's support plan, dated 8/23/19, was not signed by the resident and there was no notation of the residents inability or refusal to sign.

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.)

Licensed Practical Nurse (LPN) attempted to review Support Plan with Resident #3 on 8/31/19. Resident #3 refused participation in support plan review. Personal Care Manager verified refusal to participate on 9/11/19 during survey. Support plan was updated "Section V - Participation" by Personal Care Manager on 9/11/19.

Facility wide audit of "Support Plan" Resident Signature documentation completed by Personal Care Manager revealed no additional errors related to 2600.227.h compliance.

Personal Care Manager will re-educate all nursing staff related to the requirements of 2600.227.h, including but not limited to proper documentation related to Support Plan review documentation.

Personal Care Manager will audit the proper Support Plan documentation related to 2600.227.h , for 4 residents weekly for 3 months to ensure compliance with 2600.227.h. Resident selection will be on a rotational basis so all residents are reviewed.

The above weekly audits will be incorporated into the Quality Assurance Performance Improvement (QAPI) process/program.

Completed 09/11/2019

Legal Entity Representative

Kirk Hawthorne NHA/CEO — Signature

Kirk Hawthorne - Administrator/CEO — Printed Name and Title

10/07/2019 — Date

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231c - Preadmission Screening

Regulations

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.

Description of Violation

Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on 1/9/19. However, the resident's written cognitive preadmission screening was completed on 1/4/19.

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.)

Given that resident #4 was admitted on 1/9/19, correcting the violation of cognitive preadmission screening within the 72 hour window prior to admission can not be corrected. Facility wide audit of 2019 admissions within the Secured dementia care unit, completed by the Personal Care Manager revealed no further violations of this nature.

The Personal Care Manager is responsible for the completion of the cognitive preadmission screening requirements for the Secured Dementia Care unit. Personal Care Manager was re-educated during the survey and discussed the requirements of 2600.231.c with the surveyors and verbalizes understanding of the regulation.

Facility Administrator will audit the timely completion of the written cognitive preadmission screen for each admission to the Secured Dementia unit for the remainder of 2019.

The results of the above audit will be incorporated into the facility Quality Assurance Performance Improvement (QAPI) process/program.

Completion date: 09/11/2019

Legal Entity Representative

Kirk Hawthorne NHA/CEO
Signature

KIRK HAWTHORNE - ADMINISTRATOR/CEO
Printed Name and Title

10/02/19
Date

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