

Department of Human Services  
Bureau of Human Service Licensing

February 12, 2021

██████████ ADMINISTRATOR  
MARIA JOSEPH MANOR INC  
1707 MONTOUR BLVD.  
DANVILLE, PA 17821

RE: NAZARETH MEMORY CENTER AT  
MARIA JOSEPH  
15 SCHOOLHOUSE ROAD  
DANVILLE, PA, 17821  
LICENSE/COC#: 21115

Dear ██████████

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/10/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
Anne Graziano

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services  
Bureau of Human Service Licensing  
LICENSING INSPECTION SUMMARY**

**Facility Information**

**Name:** NAZARETH MEMORY CENTER AT MARIA JOSEPH      **Licen e #:** 21115      **Licen e Expiration Date:** 01/31/2021  
**Addr e :** 15 SCHOOLHOUSE ROAD, DANVILLE, PA 17821  
**County:** MONTOUR      **Region:** NORTHEAST

**Administrator**

**Name:** [REDACTED]      **Phone:** 5702758701      **Email:** [REDACTED]

**Legal Entity**

**Name:** MARIA JOSEPH MANOR INC  
**Address:** 1707 MONTOUR BLVD., DANVILLE, PA, 17821  
**Phone:** 5702758701      **Email:** [REDACTED]

**Certificate(s) of Occupancy**

**Type:** C-1      **Date:** 03/04/2003      **Issued By:** DEPT OF HEALTH

**Staffing Hours**

**Resident Support Staff:** 0      **Total Daily Staff:** 40      **Waking Staff:** 30

**Inspection**

**Type:** Full      **Notice:** Unannounced      **BHA Docket #:**  
**Rea on:** Renewal      **Exit Conference Date:** 11/10/2020

**Inspection Dates and Department Representative**

11/10/2020 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 24      **Residents Served:** 20

**Secured Dementia Care Unit**

**In Home:** Yes      **Area:** Building      **Capacity:** 24      **Residents Served:** 20

**Hospice**

**Current Re ident :** 0

**Number of Residents Who:**

**Receive Supplemental Security Income:** 2      **Are 60 Years of Age or Older:** 20  
**Diagnosed with Mental Illness:** 0      **Diagnosed with Intellectual Disability:** 0  
**Have Mobility Need:** 20      **Have Physical Disability:** 1

Inspections / Reviews

11/10/2020 - Full

Lead Inspector: [REDACTED]

Follow Up Type: *POC Submission*

Follow-Up Date: *12/16/2020*

12/22/2020 POC Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Document Submission*

Follow-Up Date: *01/08/2021*

2/12/2021 - Document Submission

Lead Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

63a - First Aid/CPR Training

1. Requirements

2600.

- 63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

*On 11/7/20 from 11pm to 7am the home did not have a staff person with current First aid and CPR certified training.*

REPEAT VIOLATION 11/19/19

Plan of Correction

Directed

1. No residents were affected.
2. Residents have the ability to be affected.
3. Human Resources Director and Staff Scheduler have been updated on CPR & First Aid requirements.
4. Training will be scheduled every other month or more frequently if needed. Staff Scheduler is searching for possible alternative training methods/resources due to the impact of Covid19. Training will be held as soon as a trainer is available, either on site or off site. Will be audited daily for 90 days by the Staff Scheduler, ensuring there is a CPR & First Aid trained staff member working during all shifts.
5. PC Administrator will monitor to ensure ongoing compliance. Progress will be reviewed during the Quality Management Meeting.

Directed Plan of Correction:

*The Adm will submit either the training sheet that both the staff and the Trainer have signed or a copy of the new First Aid card upon completion. Training must be IN PERSON.*

AG, 12-22-2020

Completion Date: 12/31/2020

Document Submission

Implemented

*n person CPR training will be held for staff on Jan 28. Training will be conducted by a certified trainer. See attached nvoice confirming training.*

Update - 01/26/2021

1-26-21

*Upon completion, the Adm will send either copies of the cards or a copy of the attendance sheet signed by the trainer.*

AG

65f - Training Topics

1. Requirements

2600.

- 65.f. Training topics for the annual training for direct care staff persons shall include the following:

65f - Training Topics (continued)

**Description of Violation**

Staff person A did not have training in infection control for the 2019 training year.

REPEAT VIOLATION 11/19/19

**Plan of Correction**

**Directed**

1. Staff and residents have the potential to be affected.
2. Direct care staff member A has been re-trained in infection control via Relias Learning. Staff member A was reeducated on the importance of completing the required annual training. Infection Control was also reviewed with all care staff.
3. Annual training is offered through Relias Learning or by a qualified instructor. The Staff Scheduler is tracking the courses. Audits will be conducted by the Staff Scheduler for two months.
4. The Personal Care Administrator will ensure ongoing compliance. Progress will be reviewed during the Quality Management Meeting.

Directed Plan of Correction:

Upon resubmission, the Adm will submit a copy of the employee's training. Also, the Home will submit a copy of a tracking tool already in use, or develop and submit a tool to use to avoid repeat violations for TRAINING TOPICS. AG, 12-22-2020

Completion Date: 12/14/2020

**Document Submission**

**Implemented**

Direct care staff member A is no longer employed by Nazareth Memory Center. Attached is the tracking tracking tool in use.

85a - Sanitary Conditions

**1. Requirements**

2600.  
85.a. Sanitary conditions shall be maintained.

**Description of Violation**

At approximately 1:30 p.m., Resident room [REDACTED] had an extremely strong urine odor.

REPEAT VIOLATION 11/19/19.

85a - Sanitary Conditions (continued)

**Plan of Correction**

**Directed**

1. Residents and staff have the potential to be affected.
2. Wellness Director confirmed the resident in room 120 will continue on a toileting schedule to assist with resident not urinating on the floor. Wellness Director reviewed toileting schedule ensuring it's appropriate for the resident.
3. On the day of inspection, the housekeeper began using a disinfectant spray on the carpeting to assist in eliminating the urine odor. The disinfectant is now being used daily or more frequently if needed. The Facilities Director began researching new material to replace the carpeting in the room. A material that does not retain odors will be installed upon necessary approvals my management. Date for completion of installation to be determined. The heating/ac unit in the resident's room will also be disinfected monthly or as needed.
4. Nursing, Housekeeping and Maintenance staff were educated on new cleaning routines.
5. Housekeeping and direct care staff will monitor room daily for urine odor. Progress will be reviewed during the Quality Management Meeting.

*Directed Plan of Correction:*

*Upon resubmission of the POC, the home will submit a copy of the Environmental Sheet that is actually IN USE, ncluding notes on findings and any steps taken to remediate problems found.  
f the situation regarding the urine odor have not been resolved indicate the next steps the home will be taking.  
AG, 12-22-2020*

**Completion Date:** 12/14/2020

**Document Submission**

**Implemented**

*The administrator inspected resident room [REDACTED]. The urine odor is still present despite cleaning and spraying deodorizer. The facilities director is getting a copy of the environmental sheet being used to document cleaning and deodorizing. The vendor for new floor installation has been secured; however, due to Covid19 concerns, an nstallation date has not been confirmed. Increased cleaning efforts will be made until a date is determined.*

**Update - 01/26/2021**

1-26-21

*Once a plan has been finalized and implemented, the home will submit digital photo(s) and a paid invoice. It is understood that COVID-19 is an impediment to the timely implementation of this POC.  
AG*

131f - Fire Extinguisher Inspection

**1. Requirements**

2600.

- 131.f. Fire extinguishers shall be inspected and approved annually by a fire safety expert. The date of the inspection shall be on the extinguisher.

**Description of Violation**

*The fire extinguisher located near exit door #1 had an inspection tag which had expired in October of 2020.*

131f - Fire Extinguisher Inspection *(continued)*

**Plan of Correction**

**Directed**

1. No residents were affected.
2. Residents and staff have the ability to be affected.
3. The fire extinguisher by door #1 has been inspected with a current inspection tag.
4. The Facilities Director will ensure all extinguishers are inspected annually. The Administrator will ensure compliance and review during the Quality Management Meeting.

*Directed Plan of Correction:*

*The Home will submit a digital photo of the new tag with the resubmitted POC.*

*AG, 12-22-2020*

**Completion Date:** 11/13/2020

**Document Submission**

**Implemented**

*Photo of tag attached.*

141b1 - Annual Medical Evaluation

**1. Requirements**

2600.

141.b.1. A resident shall have a medical evaluation: At least annually.

**Description of Violation**

*The annual medical evaluation (D.M.E.) , for resident # 3 did not include the "Evaluation Date" of the examination.*

**Plan of Correction**

**Directed**

1. No residents were affected.
2. Residents have the ability to be affected.
3. The DME for resident #3 was corrected. Upon admission, the resident's DME will be marked with the date of evaluation. The LPN will review the DME upon admission to ensure proper documentation and audit them quarterly.
4. Wellness Director will monitor for ongoing compliance. Progress will be reviewed during the Quality Management Meeting.

*Directed Plan of Correction:*

*Upon the Resubmission of the POC, the home will send a copy of this corrected DME. The home will also send a copy of the Audit tool that is actually IN USE to show ongoing compliance.*

*AG, 12-22-2020*

**Completion Date:** 11/13/2020

**Document Submission**

**Implemented**

*Audit tool attached. Corrected DME will be submitted on Jan. 25.*

161d - Dietary Needs

**1. Requirements**

2600.

161.d. A resident's special dietary needs as prescribed by a physician, physician's assistant, certified registered nurse practitioner or dietitian shall be met. Documentation of the resident's special dietary needs shall be kept in the resident's record.

161d - Dietary Needs *(continued)*

**Description of Violation**

*The Resident's Assessments and Support Plans for residents # 4 and # 5 did not include the prescribed special diets- "mechanical soft."*

**Plan of Correction**

**Directed**

1. *No residents were affected.*
2. *Residents have the ability to be affected.*
3. *Support plans for residents #4 and #5 were updated.*
4. *Wellness Director reeducated licensed staff on special diets ordered by the prescriber. Special diets will be documented in the Resident Assessment Support Plan when received from the prescriber at time of admission and updated as needed.*
5. *The Wellness Director will monitor for ongoing compliance. Progress will be reviewed during the Quality Management Meeting.*

*Directed Plan of Correction:*

*The Home will submit the 2 residents' RASPs that had the special dietary updates via the Portal. In addition, the Home will submit the monitoring done to date by the time the Resubmission of the Plan of Correction is resubmitted.  
AG, 12-22-2020*

**Completion Date:** 11/13/2020

**Document Submission**

**Implemented**

*Corrected RASPs will be submitted on Jan. 25.*

183e - Storing Medications

**1. Requirements**

2600.

183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

**Description of Violation**

*The Levemir insulin pen belonging to resident # 1 was not initialed by the staff person who opened the pen for use.*

183e - Storing Medications *(continued)*

**Plan of Correction**

**Directed**

1. The LPN initialed the resident's insulin pen at the time of inspection.
2. Residents who receive multiple doses of insulin have the ability to be affected.
3. Licensed staff and medication technicians have been re-educated on the requirement to initial insulin pens. Insulin will be checked for open dates, initials and expiration dates every 24 hours. Audited weekly for 4 weeks.
4. The Wellness Director will monitor to ensure ongoing compliance. Progress will be reviewed during the Quality Management Meeting.

*Directed Plan of Correction:*

The Home will submit a copy of the staff sign in sheet from the training that has been provided to the med techs. A copy of the weekly audit sheet that is actually IN USE will also be submitted for review in order to measure compliance.

AG, 12-22-2020

Completion Date: 12/11/2020

**Document Submission**

**Implemented**

Please see attached sign in sheet and audit sheet.

187d - Follow Prescriber's Orders

**1. Requirements**

2600.

187.d. The home shall follow the directions of the prescriber.

**Description of Violation**

Resident # 2 has a prescription for Tylenol to be administered 3 times daily. On 11/10/20 the resident's 8am dose of Tylenol was not initialed as administered and it was unknown if the resident received the medication.

REPEAT VIOLATION 11/19/19

**Plan of Correction**

**Directed**

1. No residents were affected.
2. Residents have the potential to be affected.
3. Medication Technicians have been re-trained by the Wellness Director on regulation 187d, specifically proper documentation when medication is administered.
4. To ensure future compliance the Wellness Director or LPN will audit med passes 2xs a week for 4 weeks to ensure compliance.
5. Progress will be reviewed during the Quality Management Meeting.

*Directed Plan of Correction:*

The Admin will include the sign in sheet from the training on 2600.187(d) in the Resubmission of the POC.

The Home will also include a copy of at least 1 audited Med Pass that has BEEN COMPLETED in order to verify compliance with this resubmitted plan of correction.

AG, 12-22-2020

Completion Date: 12/11/2020

**Document Submission**

**Implemented**

See attached training signature sheet and audit.

234d - Support Plan Revision

**1. Requirements**

2600.

234.d. The support plan shall be revised at least annually and as the resident's condition changes.

**Description of Violation**

*The Resident's Assessment and Support Plan ( R.A.S.P.) for resident # 3, dated 4/17/20, did not include the resident's recent falls and the consideration by the home to have the resident assessed for skilled care.*

**Plan of Correction**

**Directed**

1. No residents were affected.
2. Residents have the potential to be affected.
3. Resident #3 has been reassessed and the RASP has been updated.
4. Wellness Director re-educated staff on updating Resident Assessment Support Plans.
5. Wellness Director will monitor, ensuring ongoing compliance. Progress will be reviewed during the Quality Management Meeting.

*Directed Plan of Correction:*

*The Adm will submit a copy of Resident # 3's revised RASP to demonstrate compliance with the resubmitted POC. The Home will also submit a copy of the Audit Tool that is actually IN USE that is monitoring the ongoing compliance of updating of Resident Support Plans.*

AG, 12-22-2020

**Completion Date:** 11/20/2020

**Document Submission**

**Implemented**

*See attached audit tool.*