

Department of Human Services  
Bureau of Human Service Licensing

April 12, 2022

[REDACTED], ADMINISTRATOR  
[REDACTED]  
[REDACTED]

RE: SAINT JOHN XXIII HOME  
2250 SHENANGO VALLEY FREEWAY  
HERMITAGE, PA, 16148  
LICENSE/COC#: 44760

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/08/2022 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,  
[REDACTED]

Enclosure  
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

**Facility Information**

Name: *SAINT JOHN XXIII HOME* License #: *44760* License Expiration: *05/25/2023*  
Address: *2250 SHENANGO VALLEY FREEWAY, HERMITAGE, PA 16148*  
County: *MERCER* Region: *WESTERN*

**Administrator**

Name: [REDACTED] Phone: [REDACTED] Email: [REDACTED]

**Legal Entity**

[REDACTED]

**Certificate(s) of Occupancy**

Type: <i>C-1</i>	Date: <i>05/15/1971</i>	Issued By: <i>L&amp;I</i>
Type: <i>C-2 LP</i>	Date: <i>05/16/2001</i>	Issued By: <i>L&amp;I</i>
Type: <i>C-2 LP</i>	Date: <i>01/28/2005</i>	Issued By: <i>L&amp;I</i>

**Staffing Hours**

Resident Support Staff: *0* Total Daily Staff: *36* Waking Staff: *27*

**Inspection Information**

Type: *Full* Notice: *Unannounced* BHA Docket #:  
Reason: *Renewal, Complaint* Exit Conference Date: *03/08/2022*

**Inspection Dates and Department Representative**

03/08/2022 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

License Capacity: *98* Residents Served: *28*

**Secured Dementia Care Unit**

In Home: *Yes* Area: *Special Needs* Capacity: *32* Residents Served: *8*

**Hospice**

Current Residents: *0*

**Number of Residents Who:**

Receive Supplemental Security Income: <i>0</i>	Are 60 Years of Age or Older: <i>28</i>
Diagnosed with Mental Illness: <i>0</i>	Diagnosed with Intellectual Disability: <i>0</i>
Have Mobility Need: <i>8</i>	Have Physical Disability: <i>0</i>

**Inspections / Reviews**

**03/08/2022 - Full**

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *03/31/2022*

Inspections / Reviews (*continued*)

04/05/2022 - POC Submission

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: *04/15/2022*

04/12/2022 - Document Submission

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

**81b - Resident Personal Equipment**

**1. Requirements**

2600.

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

**Description of Violation**

*Resident #1 has an enabler bar on his/her bed; however, it is not secured to the bed. The bar is attached to a wooden board that is positioned between the mattress and bed frame and can be moved approximately 5 and 1/2 inches from the bed, posing an entrapment hazard.*

**Plan of Correction**

**Accept**

*1. The enabler bar for Resident #1 was properly secured, at time of discovery and verified by surveyor. Potential entrapment issue(s) were resolved. Only 1 additional enabler bar is currently in use in the facility which was properly secured. No further issues of this nature were identified.*

*2. All nursing and maintenance personnel have been re-educated by Personal Care Administrator, related to enabler installation, inherent risks of such and the need to be aware of entrapment potential by 3/31/22*

*3. Personal Care Administrator will audit enabler function/safety, for all enablers in use on a monthly basis.*

*4. The above monthly audits will be incorporated into the facility Quality Assurance/Quality Improvement process.*

**Completion Date:** 03/31/2022

**Document Submission**

**Implemented**

*see previously attached*

**85e - Trash Outside Home**

**1. Requirements**

2600.

85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

**Description of Violation**

*The lid on the right side dumpster was open and multiple trash bags were protruding out of the top of the dumpster.*

**Plan of Correction**

**Accept**

*1. Facility scheduled pick-up arrangements with Waste Management provider have been increased to each Monday, Wednesday and Friday to properly dispose of refuse prior to dumpsters being overfilled. This will enhance the ability to properly close dumpster lids.*

*2. Maintenance personnel have been re-educated by Maintenance Director, related to the scheduled garbage pick-up days and the need to properly secure refuse within dumpster(s) and close lids to prevent insect and rodent penetration by 3/31/2022*

*3. Proper dumpster utilization and refuse disposal will be audited by the Maintenance Director on a weekly basis.*

*4. The above refuse audit will be incorporated into the facility Quality Assurance/Quality Improvement program.*

**Completion Date:** 03/31/2022

85e - Trash Outside Home (*continued*)**Document Submission****Implemented***see previously attached*

## 103g - Storing Food

**1. Requirements**

2600.

103.g. Food shall be stored in closed or sealed containers.

**Description of Violation***The following food items in the walk-in freezer of the kitchen were opened and unsealed:**A box of 115 - 2.1 ounce beef patties, approximately 1/2 full**A box of 54 - 3 ounce pizza melt patties, full***Plan of Correction****Accept**

1. *The two boxes of unsealed product within the walk-in freezer were properly closed/sealed by the Dietary Manager upon discovery, as verified by surveyor. All remaining products within the walk-in freezer and cooler were properly secured.*

2. *Dietary Manager has re-educated all Dietary Personnel related to the proper storage, labeling and dating of all food by 3/31/2022*

3. *Dietary Manager will complete a weekly audit of proper food storage (Closed/sealed) throughout the kitchen.*

4. *The above Food Storage audits will be incorporated into the Quality Assurance / Quality Improvement programs.*

**Completion Date:** 03/31/2022**Document Submission****Implemented***see previously attached*

## 107c - Food/Water 3 Day Supply

**1. Requirements**

2600.

107.c. The home shall maintain at least a 3-day supply of nonperishable food and drinking water for residents.

**Description of Violation***The home served 28 residents, requiring 84 gallons of emergency drinking water. However, the home had only 48 gallons.**The home does not have a contract with a local bottled water supplier that includes delivery of potable water.***Plan of Correction****Accept**

1. *240 gallons of Emergency Drinking Water on hand was secured by Maintenance Director on 3/9/2022.*

2. *Maintenance Director is aware of 2600.107c standards related to Emergency drinking water (3 gal/resident).*

3. *Maintenance Director will verify/audit adequate Emergency drinking water supply on hand on a monthly basis.*

4. *The above audits will be incorporated into the facility Quality Assurance / Quality Improvement process.*

**Completion Date:** 03/22/2022

107c - Food/Water 3 Day Supply (continued)

Document Submission

Implemented

see previously attached

132b - Safety Inspection/Fire Drill

1. Requirements

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 last fire safety inspection and fire drill conducted by a fire safety expert was on 6/19/2019.

Plan of Correction

Accept

1. Fire Safety expert conducted a fire safety inspection on 3/23/2022.
2. Fire Safety expert inspection was not completed due to COVID-19 restrictions at the Fire Safety experts level, prior to March 2022.
3. 2022 Fire Safety Expert inspection letter is attached. The 2023 Annual Inspection has also been scheduled.
4. Annual Fire Safety expert review will be incorporated in to the facility Annual Inspection profile requirements and monitored by the Maintenance Director.

Completion Date: 03/23/2022

Document Submission

Implemented

see previously attached

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

Resident #1's [redacted] insulin pen does not indicate the date opened on the medication. Per the manufacturer's instructions, "Dispose after 28 days, even if there is insulin left in the pen or vial."

Plan of Correction

Accept

1. Resident #1\*, [redacted] insulin pen was refilled on 3/21/22. The medication pen is properly labeled (name, dosage, instructions) and includes the open date of the medication. Baseline audit of all residents revealed that all other medications were properly stored and labeled.
2. Nursing staff were educated of the labeling/dating issue of [redacted] pen by Personal Care Administrator at time of discovery. All Nursing staff have been re-educated by Personal Care Administrator related to proper storage of medications, including NovoLog Pen standards (open date / 28 day disposal) by 3/31/2022
3. [redacted] pen labeling, storage and open dating will be audited on a daily basis by Personal Care Administrator for compliance.

183e - Storing Medications (continued)

4. The Medication Storage audit above will be incorporated into the facility Quality Assurance / Quality Improvement process.

Completion Date: 03/31/2022

Document Submission

Implemented

see previously attached

184a - Labeling OTC/CAM

1. Requirements

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.
- 4. The prescribed dosage and instructions for administration.

Description of Violation

There is no pharmacy label for resident #1's [REDACTED] insulin pen indicating resident name, or instructions for administration per the prescribed sliding scale.

Plan of Correction

Accept

- 1. Resident #1\*, [REDACTED] insulin pen was refilled on 3/21/22. The medication pen is properly labeled (name, dosage and instructions) and includes the open date of the medication. Baseline audit of all residents revealed that all other medications were properly stored and labeled.
- 2. Nursing staff were educated of the labeling: Name, dosage, instructions and open dating issue of NovoLog pen by Personal Care Administrator at time of discovery. All Nursing staff have been re-educated by Personal Care Administrator related to proper storage of medications, including NovoLog Pen standards (including open date/ 28 day disposal) by 3/31/2022.
- 3. NovoLog pen labeling, storage and dating will be audited on a daily basis by Personal Care Administrator for compliance.
- 4. The Medication Storage audit above will be incorporated into the facility Quality Assurance / Quality Improvement process.

Completion Date: 03/31/2022

Document Submission

Implemented

see previously attached

187d - Follow Prescriber's Orders

1. Requirements

187d - Follow Prescriber's Orders (continued)

2600.  
187.d. The home shall follow the directions of the prescriber.

**Description of Violation**

Resident #3 is prescribed blood glucose checks three times daily before meals at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and to administrator insulin per sliding scale based on the blood glucose readings. However, resident #3's blood glucose was not checked on the following dates and times:

- 2/23/22 at 11:30 a.m.
- 2/25/22 at 11:30 a.m.
- 3/1/22 at 7:30 a.m. and 11:30 a.m.
- 3/4/22 at 7:30 a.m. and 11:30 a.m.
- 3/5/22 at 11:30 a.m.
- 3/6/22 at 11:30 a.m.

**Plan of Correction**

**Accept**

1. Staff were re-educated by Personal Care Administrator related to following physician's order (specifically Blood Glucose checks for resident R#1) upon discovery. No further issues of this nature were identified through baseline audit.
2. All nursing staff have been re-educated related to 2600.187d standards by Personal Care Administrator by 3/31/2022
3. The Personal Care Administrator will audit compliance with Blood Glucose monitoring per physician orders for all residents with such orders, on a daily basis.
4. The above audits will be incorporated into the facility Quality Assurance / Quality Improvement process.

Completion Date: 03/31/2022

**Document Submission**

**Implemented**

see previously attached

225c - Additional Assessment

**1. Requirements**

2600.  
225.c. The resident shall have additional assessments as follows:  
1. Annually.

**Description of Violation**

Resident #3's current assessment was completed on [REDACTED]. However, the resident's previous assessment was completed on [REDACTED].

225c - Additional Assessment (continued)

**Plan of Correction**

**Accept**

1. *Baseline audit of all current residents Annual Assessment revealed additional untimely assessment completion (including Resident #3).*
2. *All out of compliance Annual Resident assessments will be completed by 04/15/2022. Annual Resident Assessment Due Date tracker sheet has been implemented to properly monitor due dates and timely completion. All future Annual Assessments will be completed in accordance with 2600.225.c standards.*
3. *All Nursing Personnel will be re-educated by the Personal Care Administrator related to 2600.225c standards. The Personal Care Administrator will monitor/audit the timely completion of Annual Assessments on a weekly basis*
4. *The above audits will be incorporated into the facility Quality Assurance / Quality Improvement program.*

**Completion Date:** 04/15/2022

**Document Submission**

**Implemented**

*see previously attached*

231b - Medical Evaluation

**1. Requirements**

2600.

- 231.b. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

**Description of Violation**

*Resident #4 was admitted to the Secure Dementia Care Unit (SDCU) on [REDACTED]; however, the resident's medical evaluation was completed on [REDACTED].*

**Plan of Correction**

**Accept**

1. *Resident #4 was admitted in an emergency need situation, thus, the reason for her DME being out of compliance. Resident #4 has been seen by her attending physician and the proper diagnosis and need for secured dementia care unit is properly documented at this time. This is an appropriate placement. There have been no additional admissions to the Secured Dementia Care Unit in the past 12 months.*
2. *Personal Care Administrator has review and is aware of the 2600.231.b standards.*
3. *Facility CEO will audit the proper/timely completion (2600.231.b compliance) of DME for all future admissions to the secured dementia care unit.*
4. *The above audits will be incorporated in to the facility Quality Assurance / Quality Improvement programs.*

*By 4/15/22 - Resident #4 will have a medical evaluation completed by a physician or other qualified individual on the Department's DME form and placed in the resident's record.*

JW 4/5/22

**Completion Date:** 03/22/2022

231b - Medical Evaluation *(continued)*

**Document Submission**

**Implemented**

*new attachments:*

*Medical Evaluation*

*Nursing training signature sheets*

91 - Telephone Numbers

**1. Requirements**

2600.

91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

**Description of Violation**

*There are no emergency telephone numbers posted on or near the two cordless telephones in resident #2's bedroom.*

*Repeat Violation: 2/25/21*

**Plan of Correction**

**Accept**

*1. Emergency telephone numbers were provided/posted in Resident #2 bedroom at time of discovery, as verified by surveyor. Resident #2 later indicated that ■ disposed of the previously provided numbers as ■ "didn't need them". Facility wide baseline audit identified no additional issues of this nature.*

*2. Nursing personnel have been re-educated by Personal Care Administrator related to the requirement that Emergency telephone numbers must be post on or by each telephone with an outside line.*

*3. Personal Care Administrator will audit Emergency Telephone numbers posted near/on each telephone with an outside line on a monthly basis.*

*4. The above "Emergency telephone number" audits will be incorporated into the facility Quality Assurance / Quality Improvement process.*

**Completion Date:** 03/22/2022

**Document Submission**

**Implemented**

*See previously attached:*

*Audit*