

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

March 14, 2023

[REDACTED], ADMINISTRATOR
MARIA JOSEPH MANOR INC
[REDACTED]

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

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/05/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: NAZARETH MEMORY CENTER AT MARIA JOSEPH **License #:** 21115 **License Expiration:** 01/31/2024

Address: 15 SCHOOLHOUSE ROAD, DANVILLE, PA 17821

County: MONTOUR **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: MARIA JOSEPH MANOR INC

Address: [REDACTED]

Certificate(s) of Occupancy

Type: C 1 **Date:** 03/04/2003 **Issued By:** DOH

Staffing Hours

Resident Support Staff: 22 **Total Daily Staff:** 66 **Waking Staff:** 50

Inspection Information

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

Reason: Renewal, Complaint **Exit Conference Date:** 01/05/2023

Inspection Dates and Department Representative

01/05/2023 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 24 **Residents Served:** 22

Secured Dementia Care Unit

In Home: Yes **Area:** n/a **Capacity:** 24 **Residents Served:** 22

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 22

Diagnosed with Mental Illness: 1 **Diagnosed with Intellectual Disability:** 0

Have Mobility Need: 22 **Have Physical Disability:** 0

Inspections / Reviews

01/05/2023 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 02/03/2023

Inspections / Reviews *(continued)*

03/06/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 03/13/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 03/13/2023

03/14/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 03/13/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

16c - Written Incident Report

1. Requirements

2600.

16.c. The home shall report the incident or condition to the Department’s personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

The fire alarm was activated on 7/13/22 at 8:46 am. The fire department responded to the building. The incident was not reported to the department.

Plan of Correction

Accept () - 03/06/2023

- 1. violation corrected on 1/5/23
- 2. wellness director/administrator will report incidents within 24 hours of the incident
- 3. Administrator and Wellness director will monitor to make sure there is ongoing compliance and will be reviewed in quality management meeting

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented () - 03/14/2023

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident’s assessment and support plan.

Description of Violation

The home currently serves 22 residents in a secured dementia care unit. 3 of the residents require the assistance of two people to transfer in the event of an emergency. The other 19 residents require constant cuing and supervision in the event of an emergency. The home routinely has two staff persons working the overnight shift. In the event of an emergency the home cannot meet the needs of the residents based on their assessments and support plans.

Plan of Correction

Accept () - 03/06/2023

- 1. Policy is being revised to include a staff member for third shift in case of emergencies. ex: fire drills
- 2. Administrator and Wellness Director will review assessment support plans weekly and discuss with Scheduler to ensure proper staffing is on schedule for third shift emergencies.

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented () - 03/14/2023

65a - FS Orientation 1st Day

3. Requirements

2600.

65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

- 1. Evacuation procedures.
- 2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
- 3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.

65a FS Orientation 1st Day (continued)

4. Smoking safety procedures, the home’s smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Direct care staff member A hired [REDACTED] did not receive the 1st day fire safety orientation.

Plan of Correction

Accept ([REDACTED] - 03/06/2023)

1. Violation corrected on 1/5/23
2. DCS Member A was trained on fire safety on 1/5/23
3. Orientation Packet will be signed by all trainers at orientation
4. Administrator will sign off orientation packet when training is completed and prior to packet being filed to ensure ongoing compliance.
5. New hires and orientation packets will be review at Quality Meeting to ensure compliance

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented ([REDACTED] - 03/14/2023)

65b - Rights/Abuse 40 Hours

4. Requirements

2600.

- 65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
 3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
 4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff member A hired [REDACTED] did not receive training in resident rights, emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

Direct care staff member B hired [REDACTED] did not receive training in emergency medical plan and reporting of reportable incidents and conditions within the first 40 hours worked.

Plan of Correction

Accept ([REDACTED] - 03/06/2023)

1. Violation corrected on 1/5/23
2. DCS Member A and B received resident rights, emergency medical plan, and reporting of reportable incidents and conditions training on 1/5/23.
3. Orientation Packet will be signed by all trainers at orientation
4. Administrator will sign off orientation packet when training is completed and prior to packet being filed to ensure ongoing compliance.
5. New hires and orientation packets will be review at Quality Meeting to ensure compliance

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented ([REDACTED] - 03/14/2023)

65d - Initial Direct Care Training

5. Requirements

2600.

65.d. Direct care staff persons hired after April 24, 2006, may not provide unsupervised ADL services until completion of the following:

2. Successful completion and passing the Department-approved direct care training course and passing of the competency test.

Description of Violation

Direct care staff member A hired [REDACTED] and Direct care staff member B hired [REDACTED] did not complete the online direct care competency course.

Plan of Correction

Accept ([REDACTED]) - 03/06/2023)

1. Violation corrected for Member A on 1/7/23
2. Violation corrected for Member B on 1/8/23
3. Direct Care Competency Course completed by Member A on 1/7/23 and Member B on 1/8/23
4. New Hires will complete Direct Care Competency Course at time of orientation and certificate will be printed and put in HR file

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented ([REDACTED]) - 03/14/2023)

132c - Fire Drill Records

6. Requirements

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The evacuation time for the fire drills conducted from 1/22-7/22 was not the exact time for evacuation in mins and seconds. The time was rounded up to the nearest minute.

Plan of Correction

Accept ([REDACTED]) - 03/06/2023)

1. Violation corrected on 8/31/22
2. Exact times (mins and secs) were added to the fire drill log effective 8/31/22
3. Maintenance director instructed staff on how to record a fire drill
4. Maintenance supervisor will make that exact times including secs will be recorded on fire drill log
5. Maintenance Director will monitor to ensure continued compliance with regulation

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented ([REDACTED]) - 03/14/2023)

132h - Designated Meeting Place

7. Requirements

2600.

132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

132h - Designated Meeting Place (continued)

Description of Violation

Staff interviews indicated that all of the residents are not being evacuated during the fire drills. The residents that would have to evacuate outside are kept inside by the door when the weather is inclement.

Plan of Correction

Accept () - 03/06/2023)

1. Violation corrected on 1/12/23
2. Staff Meeting held on 1/12/23 discussed evacuation of residents on fire drills
3. Residents will be evacuated to a safe meeting place outside the building during fire drills
4. Staff will make sure residents are evacuated outside the building
5. Maintenance won't stop time from running till all staff and residents have evacuated the building during fire drills.

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented () - 03/14/2023)

185a - Implement Storage Procedures

8. Requirements

- 2600.
- 185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

The homes narcotic count policy is for the oncoming and off going staff member to sign the narcotic count sheet. On 1/4/23 the off going 2nd shift staff did not sign the narcotic count sheet.

Plan of Correction

Accept () - 03/06/2023)

1. Violation corrected on 1/12/23
2. Medication Tech and LPNs were educated on 1/12/23 of policy regarding signing on and off cart at beginning and end of shift
3. Wellness Director will monitor Narc book twice a week to ensure compliance

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented () - 03/14/2023)

187a - Medication Record

9. Requirements

- 2600.
- 187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
12. Diagnosis or purpose for the medication, including pro re nata (PRN).

Description of Violation

Resident #1's () did not include a diagnosis or purpose on the MAR.

Plan of Correction

Accept () - 03/06/2023)

1. Violation corrected on 1/12/23
2. Med Techs and LPNs were educated on MARs and making sure diagnosis are for each medication
3. Wellness director will monitor MAR book once a week to ensure all medications order by physician have a

187a - Medication Record (continued)

diagnosis and are completed in their entirety to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented (████) - 03/14/2023)

187c - Refusal of Medication

10. Requirements

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 8pm medications on ██████ the prescriber was not notified regarding the refusals.

Plan of Correction

Accept (████) - 03/06/2023)

1. Violation corrected on 1.12.23
2. Med tech and lpns were educated on policy of refusal of medications
3. Wellness director will monitor folder of med refusals weekly to ensure that the physicians were notified and to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented (████) - 03/14/2023)

231c - Preadmission Screening

11. Requirements

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

The cognitive pre-screening portion of the pre-admission screening dated ██████ is not dated as to when the cognitive pre-screening was completed.

Plan of Correction

Accept (████) - 03/06/2023)

1. Violation corrected on 1/5/23
2. Prescreen day 2 was dated to reflect date the physician signed cognitive portion of prescreen.
3. Administrator/admissions will ensure that new move ins have all prescreen paperwork dated and completed in its entirety at the time of move in to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 02/03/2023

Implemented (████) - 03/14/2023)