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

March 29, 2023

[redacted]
ROMAN CATHOLIC DIOCESE OF ERIE
2250 SHENANGO VALLEY FREEWAY
HERMITAGE, PA, 16148

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 02/14/2023, 02/15/2023 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: *SAINT JOHN XXIII HOME* **Licen e #**: *44760* **Licen e 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

Name: *ROMAN CATHOLIC DIOCESE OF ERIE*

Address: *2250 SHENANGO VALLEY FREEWAY, HERMITAGE, PA, 16148*

Phone: [redacted] **Email** [redacted]

Certificate(s) of Occupancy

Type: *C 1*	**Date**: *06/15/1971*	**I ued By**: *L&I*
Type: *C 2 LP*	**Date**: *01/26/2005*	**I ued By**: *L&I*
Type: *C 2 LP*	**Date**: *05/16/2010*	**I ued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/15/2023*

Inspection Dates and Department Representative

02/14/2023 On Site [redacted]

02/15/2023 On Site

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Special Needs* **Capacity**: *32* **Residents Served**: *6*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

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

Have Mobility Need: *7* **Have Physical Disability**: *0*

Inspections / Reviews

02/14/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/03/2023*

Inspections / Reviews *(continued)*

03/02/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *03/27/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/09/2023*

03/07/2023 - POC Submission

Submitted By [redacted] **Date Submitted:** *03/27/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *04/01/2023*

03/29/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *03/27/2023*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

54a - Direct Care Staff

1. Requirements

2600.
54.a. Direct care staff persons shall have the following qualifications:
2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

On 2/14/23 records indicate that direct care staff A, hired [redacted] 22, received a high school diploma from outside the United States and the home does not have a waiver.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

No additional issues of this nature were identified through review of staff records by Human Resource Director. (Completed 2/16/23)

Human Resource Director has been educated related to the "Outside the Country standard related to Diploma waiver process, by facility administrator/CEO (completed 2/16/23)

Human Resource Director worked with DHHS (Jill K.) to secure the necessary waiver related to Direct Care Staff "A". Verification of [redacted] Diploma has been received through Institute of Foreign Credential Services, Inc. (attached). Waiver has been denied due to insufficient proof of education. Employee will not be permitted to work until education standards can be met. as of date of Waiver denial on [redacted] /2023.

Human Resource Director will ensure necessary qualification are on file, through audit, with each new hire moving forward, including but not limited to waiver compliance as necessary. (2/16/23 thru 12/31/23)

HR Director will incorporate the above audits into the facility Quality Assurance / QAPI program with each QA held between 2/16/23 - 12/31/23

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

65b - Rights/Abuse 40 Hours

2. 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:

Description of Violation

On 2/14/22 records indicate that direct care staff A, hired [redacted] /22, did not receive training within the first 40 hours of employment in the following topics: Resident rights, emergency medical plan and reporting reportable incidents and conditions.

On 2/14/22 records indicate that direct care staff B, hired [redacted] /22, did not receive training within the first 40 hours of employment in the home's emergency medical plan.

On 2/14/22 records indicate that direct care staff C, hired [redacted] /20, did not receive training within the first 40 hours of employment in the following topics: Resident rights and emergency medical plan.

65b - Rights/Abuse 40 Hours *(continued)*

Plan of Correction ***Accept (JW 03/07/2023)***

Personal Care Administrator has reviewed the requirements of: 2600.65.b (completed 2/16/23), that each staff member will be trained related to Resident Rights, OAPSA, Emergency medical plan and reportable Incidents/conditions, within initial 40 scheduled working hours and completion of such is properly documented. (3/1/23 - 12/31/23)

Direct Care Staff "A": has been re-educated regarding missed training areas (Resident Rights, Emergency Medical plan and reportable incidents/conditions) by the Personal Care Administrator and training documented accordingly. Employee "A" has since been taken off schedule due to 2600.54a standards. (completed 2/24/23 attached)

Direct Care Staff "B": has been re-educated regarding missed training area: (Emergency Medical Plan) by Personal Care Administrator and training documented accordingly. (Completed 2/27/23 attached)

Direct Care Staff "C": has been re-educated regarding missed training areas" (Emergency Medical plan (completed 2/24/23 attached) by Personal Care Administrator and training documented accordingly. DCS Staff "C" was trained on Resident RIghts on 12/23/22 (attached), which was improperly documented.

Personal Care Administrator will verify/audit the completion of "40 hour" training requirements with each new hire (3/1/23 thru 12/31/23)

Documentation process of training has been revised. (Completed 3/1/23 attached)

Personal Care Administrator will incorporate the above audits into the facility Quality Assurance / QAPI program for each QA meeting held between 3/1/23 through 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

On 2/14/22 records indicate that direct care staff C, hired [redacted]/20, did not receive annual training during the 2022 training year in the following topics: medication self-administration, instruction on meeting the needs of the resident (DME, RASP), personal care service needs.

Plan of Correction ***Accept [redacted] 03/07/2023)***

Personal Care Administrator has reviewed the requirements of 2600.65.f that each staff member will be trained related to each standard in 2600.65.f and each training be properly documented. (completed 2/15/23)

Direct Care Staff "C" was educated by the Personal Care Administrator regarding: Instructions on Meeting needs of resident (DME, RASP), (Completed 2/24/23 attached). Direct Care Staff "C" did receive training on Medication self administration and Personal Care service needs on 11/29/22, which was improperly documented. (Completed 11/29/22 attached).

65f - Training Topics (continued)

Personal Care Administrator will re-educate each current staff member regarding the annual training requirements/expectations of 2600.65f related to their job duties. (completed 3/1/23 attached)

Personal Care Administrator will monitor/audit each direct care staff members progress with required training on a monthly basis. (including proper documentation of such). (will be completed 3/1/23 thru 12/31/23)

Personal Care Administrator will incorporate the above audits and progress/status of each staff members education n each Quality Assurance / QAPI held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

65g Annual Training Content

4. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

Description of Violation

On 2/14/22 records indicate that direct care staff C, hired [redacted]/20, did not receive annual training during the 2022 training year in the following topics: fire safety and emergency preparedness.

Plan of Correction ***Accept [redacted] 03/07/2023)***

Direct Staff "C": was educated related to: fire safety, evacuation procedures and emergency preparedness on 11/29/22, which was improperly documented. [redacted] was also included in the Fire Evacuation Training from 2600.132a citation. (completed 2/22/23). attached .

No further issues of this nature have been identified through training review. The Annual training program/documentation process will be revised by Personal care Administrator as corrective action, including documentation process (complete by 3/24/23).

Personal Care Administrator has re-educated each current staff member regarding the annual training requirements/expectations of 2600.65g related to their job duties. (completed 3/1/23) attached

Personal Care Administrator will monitor/audit each direct care staff members progress on a monthly basis and erify Annual training requirement is met within training year. (including 2600.65. and proper documentation of such) (3/1/23 - 12/31/23)

Personal care Administrator will incorporate the above audits of each staff members education into each Quality Assurance / QAPI meeting held between 3/1/23 through 12/31/23).

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

65i - Training Record

5. Requirements

2600.
65.i. A record of training including the staff person trained, date, source, content, length of each course and copies of any certificates received, shall be kept.

Description of Violation

On 2/14/22 records indicate that the home's record of training for the 2022 training year for direct care staff C's does not include the length and source of the training for the following topics: fall prevention, resident rights, infection control and abuse (OAPSA).

Plan of Correction ***Accept (- 03/07/2023)***

Direct Care Staff "C": 2022 training record will be completed in entirety and documented properly, including length and source of training for fall prevention, resident rights, infection control and Abuse (OAPSA) or re training will be completed. Education provided by Personal Care Administrator. (completed 3/1/23 attached).

Documentation of Annual Training will be revised by Personal Care Administrator, as a result of the citation to better meet needs/standards of 2600.65.i. (Complete by 3/24/2023).

Personal Care Administrator will monitor/audit each direct care staff members progress on a monthly basis and verify training compliance and documentation of such. (Complete 3/1/23 through 12/31/23)

he Personal Care Administrator will incorporate the above audits related to staff training progress and documentation of such into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented - 03/29/2023)

85d - Trash Receptacles

6. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 2/14/23 there were observed two uncovered trash cans, one approximately ½ full and one approximately ¼ full, in the kitchen. Food preparation was not occurring at the time.

Plan of Correction ***Accept - 03/07/2023)***

This issue was rectified at time of identification as verified by surveyor. (Completed 2/14/23) Photos attached

Environmental services and Dietary personnel will be re-educated related to trash receptacles being covered 2600.85.d), by their respective Department Manager. (Completed 3/1/23 attached)

No additional issues of this nature were identified outside of the dietary department (kitchen). (completed 2/14/23)

Dietary Manager will audit Kitchen Area compliance with 2600.85d on a daily basis 2/14/23 thru 5/31/23.

Dietary Manager will incorporate the above audits into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

85d - Trash Receptacles *(continued)*

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] 03/29/2023)

88a - Surfaces

7. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 2/14/23 there were observed 12 ceiling tiles with brown water damage in the hallway between bedroom [redacted] and bedroom [redacted]

On 2/14/23 there was observed 1 tile with a 12 x 12 inch area with brown water damage in the eyewash room next to bedroom [redacted].

Plan of Correction ***Accept [redacted] - 03/07/2023)***

The stained ceiling tile between room [redacted] and in storage room next to room [redacted] have been replaced by Maintenance personnel. (completed 2/28/23) photos attached.

No additional stained ceiling tile was identified through facility wide audit at time of survey. (completed 2/14/23)

Environmental Service Director will complete an audit of the entire facility on a quarterly basis (3/1/23 - 12/31/23), related to damaged/stained ceiling tile.

Environmental Services Direct will incorporate the above audits into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] 03/29/2023)

103f - Refrigerator/Freezer Temps

8. Requirements

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

On 2/14/23 there was no thermometer in the refrigerator and freezer sections of the refrigerator in the Roncalli kitchenette.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

Thermometer was placed in refrigerator and freezer within Roncalli kitchenette, time of discovery. (completed 2/14/23) Photo attached.

103f - Refrigerator/Freezer Temps (continued)

Environmental Services personnel are responsible for monitoring refrigerator/freezer temperatures and thermometers in place in each refrigerator/freezer on a weekly basis.

All Environmental services personnel have been re-educated by Environmental Service Director related to refrigerator/freezer temperature standards, as well as, requirement to have a thermometer in each refrigerator/freezer. (standards of 2600.103.1) (Completed 3/1/23) attached

Environmental Services Director will audit the compliance of 2600.103.1 (proper temps and thermometer present) for all refrigerators/freezers, on a monthly basis. (2/15/23 - 12/31/23) Attached

The above audits will be incorporated into the facility Quality Assurance / QAPI program by Environmental Service Director throughout 2023.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

132a - Monthly Fire Drill

9. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

The home routinely conducts fire drills on the last day of the month. On 2/14/23 records indicated that the home conducted fire drills on 1/30/22, 2/28/22, 3/31/22, 4/30/22, 5/30/22, 6/30/22, 7/30/22, 8/31/22, 9/30/22 and 1/30/23.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

Fire drills are unannounced and will be conducted monthly on a staggered rotation (time of month) throughout the year by the Maintenance Director. (2023 scheduled developed/completed 3/1/23) attached.

Maintenance Director has been reeducated regarding the standards of 2600.132a as verified at time of survey. (completed 2/15/23)

Unannounced Fire Drill conducted on 2/22/23 (attached).

Facility Administrator/CEO will audit the adherence to the established 2023 Fire Drill schedule and the execution of the monthly fire drills, on a monthly basis related to being unannounced and random in nature. (monthly audit 2/22/23 thru 12/31/23.

The Administrator/CEO will incorporate the above audits into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] 03/29/2023)

132h - Designated Meeting Place

10. 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.

Description of Violation

According to multiple resident and staff interviews, during fire drills conducted on 1/30/22, 2/28/22, 3/31/22, 4/30/22, 5/30/22, 6/30/22, 7/30/22, 8/31/22, 9/30/22, 10/10/22, 11/28/22, 12/28/22 and 1/30/23, residents did not evacuate to a designated meeting place away from the building or a fire safe area.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

All facility personnel have been re educated related to Fire Evacuation with each Fire Drill and the Designated meeting place, by the Personal Care Administrator/Maintenance Director. (completed 2/22/23 through 3/4/23)

nannounced Fire drill conducted on 2/22/23 with evacuation outside to designated meeting place(s) all of which are documented. (attached).

acility Administrator/CEO will audit the monthly fire drill evacuation compliance on a monthly basis. (2/22/23 thru 2/31/23)

he Administrator/CEO will incorporate the above audits into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

141b1 - Annual Medical Evaluation

11. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

On 2/14/23 it was observed that resident #1 uses a bed enabler affixed to the resident's bed. However, records indicated that the resident's annual medical evaluation, dated [redacted]/23, did not order or identify the resident's need for the device or how the devices will assist in meeting the resident's needs. Additionally, section 7 – Medications indicates "see current medication list" however no medication list was attached.

Resident #2's annual medical evaluation, dated [redacted]/23, section 7 – Medications indicates "see current medication list" however no medication list was attached.

Plan of Correction ***Accept [redacted] - 03/07/2023)***

Resident #1: Physician order obtained / Annual medical evaluation updated related to the enabler bar, need for such and how the device will assist in meeting resident's needs. In addition, the current medication list has been attached. (Completed 3/1/23) attached.

Resident #2: Annual medical evaluation has been updated to include the current medication list. (Completed 3/1/23 attached)

All Nursing staff have been educated by Personal Care Administrator, regarding 2600.141.b.1, including but not

141b1 - Annual Medical Evaluation (continued)

imited to enabler bar and ensuring medication list is included with the annual medical evaluation. (completed 3/1/23 attached)

PC Administrator will complete a baseline audit of each current residents Annual Medical Evaluation (2/1/6/23 thru 3/24/23) to ensure they are complete and accurate, including but not limited to the current medication list inclusion.

PC Administrator will audit each new Annual evaluation upon completion for completeness 3/1/23 thru 5/31/2023.

Personal Care Administrator will incorporate the above audits into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

On 2/14/23 resident #2's [redacted] and [redacted] flex pen which were opened and stored in the medication cart, did not have pharmacy labels which included the date the prescription was issued, the prescribed dosage and instructions for administration and the name and title of the prescriber.

Repeat Violation: 3/8/22

Plan of Correction ***Accept [redacted] - 03/07/2023)***

Resident #2: [redacted] and [redacted] were properly labeled at time of discovery with: resident name, physician/title, date prescription issued, prescribed dosage and instructions for administration as verified by surveyor. (completed 3/1/23) photos attached.

All nursing staff have been re-educated related to medication labeling (2600.184.a): name, dosage, instructions, open date, dosage, by Personal Care Administrator. Completed 3/3/23 attached.

[redacted] pen labeling, storage and dating will be audited on a daily basis by Personal care Administrator for compliance. (Daily audit: 2/15/23 thru 3/31/2323, then monthly: 4/1/23 thru 5/31/23)

The Personal Care Administrator will incorporate the above Medication labeling audit into each facility Quality Assurance / QAPI meeting held between 3/1/23 thru 12/31/23.

Licensee's Proposed Overall Completion Date: *03/24/2023*

Implemented [redacted] - 03/29/2023)