

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

May 2, 2023

[REDACTED], ADMINISTRATOR
PAXTON STREET HOME BENEVOLENT SOCIETY INC
2001 PAXTON STREET
HARRISBURG, PA, 17111

RE: PAXTON STREET HOME
BENEVOLENT SOCIETY
2001 PAXTON STREET
HARRISBURG, PA, 17111
LICENSE/COC#: 34201

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/12/2023, 04/13/2023 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: PAXTON STREET HOME BENEVOLENT SOCIETY **License #:** 34201 **License Expiration:** 07/24/2023
Address: 2001 PAXTON STREET, HARRISBURG, PA 17111
County: DAUPHIN **Region:** CENTRAL

Administrator

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

Legal Entity

Name: PAXTON STREET HOME BENEVOLENT SOCIETY INC
Address: 2001 PAXTON STREET, HARRISBURG, PA, 17111
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP **Date:** 02/01/1995 **Issued By:** Labor and Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 78 **Waking Staff:** 59

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 04/13/2023

Inspection Dates and Department Representative

04/12/2023 - On-Site: [REDACTED]
04/13/2023 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 85 **Residents Served:** 78

Secured Dementia Care Unit

In Home: No **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 66 **Are 60 Years of Age or Older:** 48
Diagnosed with Mental Illness: 37 **Diagnosed with Intellectual Disability:** 29
Have Mobility Need: 0 **Have Physical Disability:** 8

Inspections / Reviews

04/12/2023 Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 04/28/2023

05/01/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 05/02/2023
Reviewer: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 05/08/2023

Inspections / Reviews *(continued)*

05/02/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 05/02/2023

[REDACTED] [REDACTED]

Follow Up Type: *Not Required*

130e - Hearing Impairment

1. Requirements

2600.

130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident 1 is unable to hear the fire alarm system. The home does not have a signaling device approved by a fire safety expert and tested to ensure that Resident 1 is alerted in the event of a fire.

Plan of Correction

Accept ([redacted] - 05/01/2023)

- 4/13/23 - Fire Safety Expert installed a strobe in resident #1's room.
 - 4/17/23 - Director of Resident Services identified 5 additional resident rooms currently occupied by residents who have been diagnosed with moderate hearing impairment and who wear hearing aids, where strobes are not currently installed.
 - 4/18/23 - Director of Facilities contacted the fire alarm system company to order strobes for those 5 additional rooms.
 - Two more strobes were obtained on 4/24/23 along with one additional strobe that maintenance had on hand. These 3 strobes will be installed by 5/5/23. The availability/delivery date of additional strobes currently remains undetermined. They will be installed as soon as possible after the parts are received.
 - While the 5 identified rooms remain not equipped with strobes written notices were placed in the fire tag box. In the event of a fire alarm activation those notices will direct staff responding to each area to proceed directly to the impaired individuals' room(s) to assure they have responded to the alarm, before proceeding to check all remaining resident rooms in that area as part of the existing evacuation procedures.
 - Going forward, any current Paxton Street Home resident who is newly diagnosed with moderate to severe hearing impairment (e.g.: requiring hearing aids) will have a strobe installed in their current room, or will be moved to a room containing a strobe. Until they have a strobe in their room a notice will be place in the fire tag box. In the event of a fire alarm activation those notices will direct staff responding to the area of that room to proceed directly to the impaired individual's room to assure they have responded to the alarm, before proceeding to check all remaining resident rooms in that area.
 - In the future, in cases involving individuals seeking to be admitted to Paxton Street Home who have moderate to severe hearing impairment, they will only be admitted to a room containing strobes. If no room with a strobe installed is available the hearing-impaired individual's admission will be delayed until such time as a room with a strobe becomes available.
- 4/27/23 - Director of Resident Services notified Admission Coordinator of the above changed procedure related to screening and admission. Admission Coordinator has added a question related to hearing impairment to the prescreening question list.

Licensee's Proposed Overall Completion Date: 05/05/2023

Implemented ([redacted] - 05/02/2023)

183b - Meds and Syringes Locked

2. Requirements

2600.

183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

183b Meds and Syringes Locked (continued)

Description of Violation

On [redacted] at [redacted], a bottle of [redacted] and bottle of [redacted] was unlocked and accessible in Resident 2's bedroom. Resident 2 does not have an order to self administer these medications.

Plan of Correction

Accept [redacted] - 05/01/2023)

- 4/13/23 Director of Resident Services spoke to resident #2's son in Law, who provided the resident with the medications, educating him about the need for the PCP to approve use of all OTC meds, as well as the need for PCP to authorize any medications that can be kept in a resident's room.
- 4/13/23 Director of Resident Services spoke to resident #2 and explained the need to remove the medications from his room, obtained his agreement and removed [redacted] nasal spray and [redacted] cough medication from his room.
- On 4/25/23 Director of Resident Services educated residents at the scheduled monthly community meeting about the regulatory requirements and their rationale, regarding medications kept in resident rooms, including the need for all medications kept in resident rooms to be kept locked. Residents were informed of the impending check of all resident rooms and told any unauthorized medications will need to be removed from resident rooms. This information will be reviewed with residents again at the next scheduled community meeting on 5/30/23.
- On 4/26/23 Medication Services Manager assembled a list of all residents with medications approved to be kept and used in the resident's room. All 79 occupied resident rooms will be checked by 5/5/23 for any unauthorized medications. Medications will be moved to the med room or held pending physician approval.
- On 4/27/23 Medication Services Manager emailed all resident Designated Persons', informing them about the regulatory requirements for medications being located in a resident room, along with a reminder not to provide OTC medications (including topical) to residents unless there is specific a physician's approval in place. Continue current practice of educating and reminding staff to be observant and to immediately report to the shift team leader when medications or OTC meds are seen in a resident room.

Licensee's Proposed Overall Completion Date: 05/05/2023

Implemented [redacted] - 05/02/2023)

185a - Implement Storage Procedures

3. 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 home's policy for controlled substances does not address the storage and security of schedule 3 and schedule 4 controlled substances. The home performs medication counts for schedule 2 controlled substances at the end of each shift but does not perform the same counts for schedule 3 and schedule 4 controlled substances.

Plan of Correction

Accept [redacted] - 05/01/2023)

- Our facility policy had been to double count at each shift change, and store in lock boxes only the blister cards containing schedule II controlled medications. Previously, blister cards containing schedule III and schedule IV controlled medications were stored either in the PRN drawer in the med cart or in the individual's slot in the med cart, and were not double locked and counted at shift change.
- Effective Friday 4/21/23 we implemented a new procedure and updated our medication storage and disposal policy (see attached). Staff will now double count and store the blister cards containing schedules II, III, & IV controlled medications in a similar manner to how we previously handled schedule II controlled medications, with

185a Implement Storage Procedures (continued)

slight modifications to enhance security. We will now be using the pharmacy count sheets (which remain with each blister card containing a schedule II, III, or IV controlled medication in the med cart lock box) only to document administrations of those medications. A new Controlled Medication Log binder has been created, which documents those counts, which are completed at each shift change, in a location separate from the medications and their accompanying pharmacy count sheets. Additionally, our med carts are under video surveillance (top of the cart and drawers where staff access medications only, not areas occupied by residents receiving meds).

This information was conveyed to meds staff via email on 4/21/23 (see attached "Controlled med Procedures" and the sample "Controlled Med Log"). This will also be reviewed at the next department meeting on 5/10/23.

Licensee's Proposed Overall Completion Date: 05/10/2023

Implemented () - 05/02/2023

225a - Assessment 15 Days

4. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident 1's assessment, dated (), does not include the resident's need for supervision or assistance required with medication administration.

Plan of Correction

Accept () - 05/01/2023

- 4/12/23 Resident Care Manager corrected the RASP for resident #1 to indicate that staff administer the resident's medications. (correction provided on site during inspection)
- On 4/24 & 4/26/23, Resident Support Assistant reviewed all current RASPs for residents. She confirmed that RASPs for all residents' medication sections are properly completed, and those residents whose medications are administered by PSH staff contain proper documentation stating that PSH staff administer the individual's medications. (Attached email)
- On 4/26/23 Resident Care Manager met with current Resident Support Coordinators (who complete all our resident RASPs) reviewing requirements for proper completion of all sections of RASPs, particularly the area indicating how medications are to be administered.

Training (as detailed above) will be used for any new Resident Support Coordinators, assuring proper completion of RASPs.

Licensee's Proposed Overall Completion Date: 04/27/2023

Implemented () - 05/02/2023