

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

August 3, 2023

[REDACTED], ADMINISTRATOR  
BISHOP PELCZAR MANOR  
856 CAMBRIA STREET  
CRESSON, PA, 16630

RE: JOHN PAUL II MANOR  
856 CAMBRIA STREET  
CRESSON, PA, 16630  
LICENSE/COC#: 30318

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/07/2023 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: JOHN PAUL II MANOR License #: 30318 License Expiration: 01/01/2024  
 Address: 856 CAMBRIA STREET, CRESSON, PA 16630  
 County: CAMBRIA Region: CENTRAL

**Administrator**

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

**Legal Entity**

Name: BISHOP PELCZAR MANOR  
 Address: 856 CAMBRIA STREET, CRESSON, PA, 16630  
 Phone: [REDACTED]

**Certificate(s) of Occupancy**

Type: C-2 LP Date: 09/16/2005 Issued By: Department of Labor & Industry

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 34 Waking Staff: 26

**Inspection Information**

Type: Full Notice: Unannounced BHA Docket #:  
 Reason: Renewal Exit Conference Date: 06/07/2023

**Inspection Dates and Department Representative**

06/07/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

General Information  
 License Capacity: 50 Residents Served: 32

Secured Dementia Care Unit  
 In Home: No Area: Capacity: Residents Served:

Hospice  
 Current Residents: 6

Number of Residents Who:  
 Receive Supplemental Security Income: 2 Are 60 Years of Age or Older: 31  
 Diagnosed with Mental Illness: 2 Diagnosed with Intellectual Disability: 1  
 Have Mobility Need: 2 Have Physical Disability: 0

**Inspections / Reviews**

06/07/2023 Full  
 Lead Inspector: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/24/2023

06/20/2023 - POC Submission  
 Submitted By: [REDACTED] Date Submitted: 07/21/2023  
 Reviewer: [REDACTED] Follow-Up Type: POC Submission Follow-Up Date: 06/26/2023

Inspections / Reviews *(continued)*

06/30/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 07/21/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 07/21/2023

08/03/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 07/21/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

3c - Post Current License

1. Requirements

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

On 6/7/2023 at approximately 10:00 AM, the home's current violation report, dated 2/15/2022, was not posted in a public place in the home.

Plan of Correction

Directed (████ - 06/30/2023)

On 6/7/2023, the 2022 licensing inspection summary and plan of corrections (attached) was posted by our information supervisor in a prominent place (on the bulletin board, adjacent to our lobby.) The 2023 licensing inspection summary and plan of correction are to be posted there as well upon completion.

(Directed)

- Beginning June 2023, a monthly audit will be completed by the Administrator or designee to ensure the licensing inspection summary issued with the most current license, as well as any additional licensing inspection summaries issued between the most current license and the receipt of the next license, remains posted in a public and conspicuous place.

Directed Completion Date: 06/30/2023

Implemented (████ 07/24/2023)

16b - Incident Policies

2. Requirements

2600.

16.b. The home shall develop and implement written policies and procedures on the prevention, reporting, notification, investigation and management of reportable incidents and conditions.

Description of Violation

The home does not have a written policy on the prevention, reporting, notification, investigation and management of reportable incidents.

Plan of Correction

Accept (████ - 06/30/2023)

On 6/15/2023 █████, administrator of the █████, developed a set of policies and procedures (see attached), effective 6/16/2023, regarding reportable incidents and conditions. Such policies and procedures were presented to supervisors at our Quality Management Meeting on 6/19/2023, reviewed, and on 6/27/2023 were presented by █████, to all employees for consideration and staff signature of understanding. They are considered implemented from this point forward beginning on 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented (████ - 08/03/2023)

25b - Contract Signatures

3. Requirements

2600.

25b Contract Signatures (continued)

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident home contract, dated [REDACTED], for Resident #1 was not signed by the resident; a notation was not made indicating the resident was given the opportunity to sign.

The resident home contract, [REDACTED] for Resident #2 was not signed by the resident; a notation was not made indicating the resident was given the opportunity to sign.

Plan of Correction

Accept [REDACTED] - 06/30/2023)

According to our information supervisor/Admissions coordinator, Resident #1 and Resident #2 had previously refused to sign these documents, however the information supervisor approached them again, at which time both agreed to sign their home contracts (see attached).

An audit was made of all home contracts and one additional correction was made of a missing signature by a previous administrator. On 6/27/2023 the administrator, [REDACTED], reviewed admissions documents and signatures, as well as resident rights, and an Admissions check list was created by the information supervisor (see attached) which will be used from this time forward (6/27/2023.)

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented ([REDACTED] - 07/24/2023)

26a - Quality Management Plan

4. Requirements

2600.

26.a. The home shall establish and implement a quality management plan.

Description of Violation

The home does not have a policy in place to implement a quality management plan. The home does not have documentation that a quality management plan was completed at least annually.

Plan of Correction

Accept [REDACTED] - 06/30/2023)

On 6/15/2023, [REDACTED] administrator of the John Paul II Manor, developed and initiated on 6/16/2023 a set of policies and procedures (attached) regarding Quality Management at John Paul II Manor. On 6/19/2023, the first Quality Management Meeting under the present administration took place, attended by the administrator and supervisors, at which the principles and policy of quality management were reviewed, and on 6/27/2023, they were presented by [REDACTED], the administrator, to all employees for consideration with their signature of understanding. These scheduled monthly meetings will address reportable incidents, conditions, and reporting procedures; complaint procedures; staff person training; licensing violations and plans of correction, if applicable; and resident or family councils, or both, if applicable) (attached). Quality Management meetings will occur prior to the monthly staff training to address any areas of concern so as to be able to share information with staff.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented ([REDACTED] - 07/24/2023)

89b - Hot Water Temperature

5. Requirements

89b - Hot Water Temperature (continued)

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 6/7/2023 at 2:30 PM, the hot water temperature in resident room # 9 measured 126 degrees Fahrenheit.

Plan of Correction

Accept (█ - 06/30/2023)

On 6/8/2023, the maintenance director adjusted the hot water temperature. █ took a further precaution to call a plumber to get a more accurate thermometer read, and on 6/15/2023 a further adjustment was made to the hot water thermostat by the maintenance director to ensure correct water temperature in the building. A reading was again taken for 10 minutes and the water temperature was confirmed within norms for compliance. Monthly water temperature checks will be taken by the maintenance director using the attached log sheet, from this day forward, 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented (█ - 07/24/2023)

96a - First Aid Kit

6. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

On 6/7/2023, the first aid kit in the nurse's station did not include a thermometer, adhesive tape, scissors, or eye coverings.

On 6/7/2023, the first aid kit by the welcome desk did not include a thermometer or eye coverings.

Plan of Correction

Accept (█ - 06/30/2023)

Five fully stocked and OSHA approved first aid kits were ordered from the Red Cross on 6/15/2023 and arrived on 6/17/2023. They were placed as follows: 1) at the nurse's station; 2) in the lobby; 3) in the kitchen; 4) in the craft room; and 5) in the maintenance room. The first aid kits will be checked monthly by the nursing supervisor to ensure the first aid kits are fully stocked, using the attached check log, from this date forward, 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented (█ - 07/24/2023)

102i - Soap Dispenser

7. Requirements

2600.

102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 6/7/2023, there was an unlabeled used bar of soap in resident room #4 which was occupied by 2 residents.

102i - Soap Dispenser (continued)

Plan of Correction

Accept ( ) - 06/30/2023)

The soap in question was discarded immediately by one of the care aides. Soap dishes were ordered by the inventory coordinator on 6/7/23 and were received on 6/12/23. On 6/12/23, these were labeled and placed in the resident's room in question by the same care aide. Other shared rooms were checked by her as well and any required soap dish replacements were made on site immediately. The next staff training on 7/18/2023 will include training on germ transmission, the need for separate soap dishes for shared bathrooms, and housekeeping will routinely use the attached log sheet which now includes checking of soap with supplies from this date forward, 6/27/2023. .

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented ( ) - 08/03/2023)

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 6/7/2023 at 1:45 PM and again at 3:00 PM, the temperature in the walk-in freezer was 12 degrees Fahrenheit.

Plan of Correction

Accept ( ) - 06/30/2023)

An appliance specialist was called who determined that the freezer was in need of additional coolant and a service call was scheduled for 6/15/2023. On 6/15/2023, coolant was added to bring the temperature to zero. The ongoing plan to monitor temperature will utilize the attached log sheet to ensure correct temperatures for freezing and refrigeration from this day forward, 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented ( ) - 07/24/2023)

107c - Food/Water 3 Day Supply

9. 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

On 6/7/2023, the home served 32 residents, requiring 96 gallons of emergency drinking water. However, the home had only 72 gallons. The home does not have a contract in place with a water supplier.

Plan of Correction

Accept ( ) - 06/30/2023)

On 6/7/2023, to compensate for an oversight in our emergency water reserves due to recent admissions, emergency water was immediately ordered by the maintenance supervisor and on 6/14/2023 was received and stored by the maintenance supervisor . Admissions procedure will make note to inform inventory personnel of new residents, requiring a change in food and water reserves, beginning today, 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented ( ) - 07/24/2023)

107d - Procedure Emergency Management Agency Submission

10. Requirements

2600.

107.d. The written emergency procedures shall be reviewed, updated and submitted annually to the local emergency management agency.

Description of Violation

The home does not have documentation that the written emergency procedures were reviewed, updated and submitted annually to the local emergency management agency.

Plan of Correction

Accept [redacted] - 06/30/2023)

On 6/13/2023 [redacted], administrator, reviewed and updated data in our Emergency Operations Plan, which was then forwarded to Cambria County Emergency Services for their review. The compliance letter requested of them dated 6/15/2023 is attached for the Department of Human Services, Bureau of Human Service Licensing.

A letter dated 6/14/2024 was also sent to Cresson Fire Department per PA 55, Regulation 2600.124.

The Emergency Operations Plan will be continuously updated as part of the John Paul II Manor monthly Safety Board meeting, held conjointly with the monthly Quality Management meeting, prior to monthly staff meetings. An updated EOP will coincide with the annual emergency preparedness staff in-service, this year on 8/29/2023, with all these policies in effect as of this date, 6/27/2023.

Licensee's Proposed Overall Completion Date: 06/27/2023

Implemented [redacted] - 07/24/2023)

132c - Fire Drill Records

11. 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 fire drill record for the drill conducted on 5/10/2023 indicates 33 residents were in the home and 33 residents evacuated. Per staff member interviews, only 32 residents evacuated as Resident #3 remained in his/her bed.

Plan of Correction

Directed [redacted] - 06/30/2023)

A formal education in fire drill requirements for the fire drill coordinator will take place on 8/29/2023 at the Fire Safety Inservice with the help of local fire responders.

[redacted], as Administrator, together with our information supervisor having access to exemptions related to fire drills, will review fire drill records on a monthly basis during the Safety Board monthly meetings, scheduled conjointly with Quality Management meetings, to ensure that fire drill records contain correct information. The next scheduled Safety Board and Quality Management meetings will be held on 7/17/2023, prior to the 7/18/2023 in-service training to be focused on Emergency Preparedness - see attached schedule).

(Directed)

- The Fire Drill Coordinator will receive education on the required documentation for a fire drill record as specified in regulation 2600.132(c). The education will be completed no later than 7/18/23 by the Administrator or designee; documentation will be kept.

132c - Fire Drill Records (continued)

Directed Completion Date: 07/18/2023

Implemented (█) - 07/24/2023)

132h - Designated Meeting Place

12. 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

During the fire drill on 5/10/2023 at 12:30 PM, Resident #3 did not evacuate to a designated meeting place away from the building or within the fire-safe area.

Plan of Correction

Directed (█) - 06/30/2023)

The staff in-service training on 8/29/2023 will involve "Fire Safety" We will designate this as Fire Safety Day at John Paul II Manor.

The fire drill coordinator and information supervisor will jointly conduct this training with documentation, with help of the local fire department. Local assistant fire chief █ has been invited to participate. Training videos and discussion will accompany this training. The fire drill coordinator will address the residents in an assembly on that day, 8/29/2023 to review fire drill practice and training.

A formal education in fire drill requirements for the fire drill coordinator will take place on 8/29/2023 at the Fire Safety Inservice with the help of local fire responders.

█, as Administrator, together with our information supervisor having access to exemptions related to fire drills, will review fire drill records at least monthly during the Safety Board monthly meetings, scheduled conjointly with Quality Management meetings, to ensure the fire drill record contains correct information and to ensure every resident is evacuated during the fire drill unless the home has proper documentation for 2600.29 Statement of Policy.

(Directed)

- Education will be provided to all staff members and residents on the requirements for participating in fire drills by 7/18/2023 by the Administrator or Designee; documentation will be kept by the home.

Directed Completion Date: 07/18/2023

Implemented (█) - 08/03/2023)

141a 1-10 Medical Evaluation Information

13. Requirements

2600.

141a 1 10 Medical Evaluation Information (continued)

- 141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician's assistant or nurse practitioner.
  2. Medical diagnosis including physical or mental disabilities of the resident, if any.
  3. Medical information pertinent to diagnosis and treatment in case of an emergency.
  4. Special health or dietary needs of the resident.
  5. Allergies.
  6. Immunization history.
  7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
  8. Body positioning and movement stimulation for residents, if appropriate.
  9. Health status.
  10. Mobility assessment, updated annually or at the Department's request.

**Description of Violation**

Resident #4's medical evaluation, dated [REDACTED], did not include special health or dietary needs of the resident, immunization history, body positioning and movement.

Resident #5's medical evaluation, dated by the physician on [REDACTED] did not include the date the resident was evaluated.

**Plan of Correction**

Directed [REDACTED] - 06/30/2023)

Resident #4 and Resident #5's DME's were updated on [REDACTED] by the information supervisor see attached documentation.

By [REDACTED], all remaining resident DME's were audited by our information supervisor with any missing information supplied.

To ensure compliance, we will implement continuing medical evaluation audits by our information supervisor beginning [REDACTED].

(Directed)

- To ensure compliance, we will implement continuing monthly medical evaluation audits by our information supervisor beginning 7/1/2023.

Directed Completion Date: 07/01/2023

Implemented [REDACTED] - 07/24/2023)

181c - Self-administration Assessment

**14. Requirements**

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

**Description of Violation**

Resident #5 self administers medications to include [REDACTED] however, resident #5 has not been assessed by a physician, physician's assistant or certified, registered nurse practitioner regarding ability to self administer medications.

181c - Self-administration Assessment (continued)

Plan of Correction

Accept ( ) - 06/30/2023)

The RN Nursing Supervisor consulted with the physician's office on 6/8/2023, who deemed it advisable to discard the medication in question, in accord with the Resident Assessment-Support Plan (RASP) and to make the necessary notation as to the removal of the OTC medication per physician's orders.

Education will be provided to all staff members to ensure they are aware of the prerequisites for a resident to self-administer medications prior to providing a resident with medications bedside. This will be presented during the 7/18/23 staff training, provided by the information supervisor. An initial audit of resident rooms will be conducted on 6/28/2023 by the RN Nursing supervisor to ensure PRN medications are not available to residents for self-administering who are not deemed competent to do so in their Resident Assessment Support Plan.

Licensee's Proposed Overall Completion Date: 07/18/2023

Implemented ( ) - 08/03/2023)

185a - Implement Storage Procedures

15. 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

Resident #2 is prescribed [redacted] inhale one via nebulizer every 6 hours as needed for breathing problems. On [redacted] Resident #2's medication was not available in the home.

Resident #1 is prescribed blood glucose checks once daily. The blood glucose checks on the glucometer did not match the numbers transcribed on the home's June 2023 Monthly Blood Sugar sheet as follows:

Glucometer reading on [redacted] at [redacted] was [redacted]-the number documented on the blood sugar sheet was [redacted]

Glucometer reading on [redacted] at [redacted] was [redacted] the number documented on the blood sugar sheet was [redacted]

Glucometer reading on [redacted] was [redacted]-the number documented on the blood sugars sheet was [redacted]

Plan of Correction

Directed ( ) - 06/30/2023)

The inhaler in question appears to have been a medication listed in error as the resident was no longer taking said medication upon his arrival to our facility. Nonetheless, the John Paul II Manor has requested a complete medication cart audit to be conducted by our contracted long term care pharmacists for a comparison of resident PRN medication orders to the medications in the home. We will work closely with our pharmacists to have training and ongoing medication cart audits. We await a start date from the pharmacists, hopefully by 7/17/23.

The glucometer reviews will begin 7/1/23. Our night staff care aide who has medication administration will be responsible for reviewing the documentation and reporting to the administrator. It is hoped that glucometer downloads can be printed and filed, with weekly records checks, and glucometer memory checks for the sliding scale resident to ensure proper dosage. Weekly reviews of glucometer records will indicate the next course of action for best practice in diabetic medication administration.

(Directed)

- All staff responsible for taking/reading blood glucose levels will receive education on the importance of properly transcribing blood glucose levels on the documentation sheet. Education will be provided by the



187d Follow Prescriber's Orders (continued)

**Plan of Correction**

Accept (█ - 06/30/2023)

*Diabetic training took place on 6/9/2023 by a visiting certified diabetic specialist (credentials attached). It is hoped that glucometer downloads can be printed and filed, with weekly records checks, and glucometer memory checks for the sliding scale resident to ensure proper dosage. Weekly reviews of glucometer records will indicate the next course of action for best practice in diabetic medication administration. The glucometer records will begin 7/1/23. Our night staff care aide who has medication administration will be responsible for reviewing the documentation and reporting to the administrator.*

**Licensee's Proposed Overall Completion Date:** 07/01/2023

**Implemented** (█ - 07/24/2023)

254b - Policy and Procedures

**18. Requirements**

2600.

254.b. Each home shall develop and implement policy and procedures addressing record accessibility, security, storage, authorized use and release and who is responsible for the records.

**Description of Violation**

*The home does not have policies and procedures for managing records.*

**Plan of Correction**

Accept (█ - 06/30/2023)

*A clearly defined policy and procedure was developed by █, the administrator, on 6/15/2023 (attached) to address who will be responsible and authorized for access to resident records active or discharged. This policy was introduced to supervisors on 6/19/2023 and to all staff on 6/27/2023. It is considered implemented today, 6/27/2023.*

**Licensee's Proposed Overall Completion Date:** 06/27/2023

**Implemented** (█ - 08/03/2023)