Department of Human Services
Bureau of Human Service Licensing

LICENSING INSPECTION SUMMARY PUBLIC

April 11, 2024

, ADMINISTRATOR
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 ,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 02/21/2024 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *SAINT JOHN XXIII HOME* **License #**: *44760* **License Expiration**: *05/25/2024*

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

County: *MERCER* **Region**: *WESTERN*

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *ROMAN CATHOLIC DIOCESE OF ERIE*

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

Phone: **Email**:

Certificate(s) of Occupancy

Type: *C-1* **Date**: *06/15/1971* **Issued By**: *L&I*

Type: *C-2 LP* **Date**: *01/26/2005* **Issued By**: *L&I*

Type: *C-2 LP* **Date**: *05/16/2010* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *19* **Waking Staff**: *14*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *02/27/2024*

Inspection Dates and Department Representative

02/21/2024 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *98* **Residents Served**: *19*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *32* **Residents Served**: *0*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *19*

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

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

Inspections / Reviews

02/21/2024 Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/15/2024*

Inspections / Reviews *(continued)*

03/08/2024 POC Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2024*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *03/29/2024*

04/11/2024 Document Submission

Submitted By: [redacted] **Date Submitted:** *03/26/2024*

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

65e - 12 Hours Annual Training

1. Requirements

2600.
65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person A received only 6.75 hours of annual training in training year 2023.

Plan of Correction ***Accept █ - 03/08/2024)***

1. Staff person (A) failed to complete █ 12 hours of Annual Training by 12/31/2023. This was identified by the Administrator and the 12 hours completed on 1/11/2024, as verified during survey.

2. Staff person (A) has been re-educated related to the need to complete Annual training within each calendar year as a condition of continued employment, by the Administrator. All other staff met their required annual training hours for 2023 (within training/calendar year).

3. All staff will be re-educated by the Administrator regarding the standards of 2600.65e, including completing such training within the designated training period (Calendar year).

4. Administrator will audit staff training progress on a monthly basis and ensure annual training is completed within the calendar year. Staff failing to meet Annual training requirements within the calendar year will not be permitted to work until training requirements have been properly met.

5. The above audits will be incorporated into the Quality Assurance and Continuous Quality Improvement program(s)

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented █ - 04/11/2024)

65f - Training Topics

2. Requirements

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

1. Medication self-administration training.
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.
3. Care for residents with dementia and cognitive impairments.
4. Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration.
5. Personal care service needs of the resident.
6. Safe management techniques.
7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person A did not receive training in the following during training year 2023:

Medication self-administration

Instructions on meeting the needs of residents as described in pre-screen, assessment, DME, RASP

65f Training Topics (continued)

Care of residents with dementia and cognitive impairment
Infection control and general principles of cleanliness and hygiene and areas associated with immobility.
Personal Care service needs of the resident
Safe management techniques
Care for residents with mental illness
Emergency preparedness procedures

Plan of Correction ***Accept ██ - 03/08/2024)***

1. Staff person (A) failed to meet ██ 12 hours of annual training by 12/31/2023. This was identified by the Administrator and training was completed in January 2024. The missed training was completed between 1/4/2024 1/11/2024, as verified during survey.

2. Staff person (A) has been re educated related to the need to complete Annual training for Direct Care staff, within each calendar year as a condition of continued employment, by the Administrator. All other staff met their required annual training hours for 2023.

3. All staff will be re educated by the Administrator regarding the standards of 2600.65f, including training topics and completing such training within the designated training period (Calendar year).

4. Administrator will audit staff training progress on a monthly basis and ensure annual training for Direct Care Staff is completed within the calendar year. Staff failing to meet Annual training requirements within the calendar year will not be permitted to work until training requirements have been properly met.

5. The above audits will be incorporated into the Quality Assurance and Continuous Quality Improvement program(s)3.

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented (██ - 04/11/2024)

65g - Annual Training Content

3. 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

Staff persons A, B and C did not receive training in the Older Adult Protective Services Act in the 2023 training year.

65g - Annual Training Content *(continued)*

Plan of Correction ***Accept (- 03/08/2024)***

Staff persons A, B and C did in fact have "Older Adult Protective Services Act" (OAPSA) training in 2023. This training is incorporated into the Resident Rights training program and was not properly recorded on the training log(s). OAPSA training was conducted as follows: Employee A (5/11/23), Employee B (5/9/23) and Employee C (5/10/23). This is a clerical error not an education/training liability.

2. Full staff audit completed by Administrator confirms that all staff members received OAPSA training in 2023 as part of the Resident Rights training materials.

3. Administrator is responsible for Annual Training requirements, education standards/materials and accurate documentation of such. Administrator has reviewed the standards of 2600.65.g and has implemented revised documentation processes moving forward.

4. All staff will be re-educated regarding the standards of 2600.65.g and the required annual training topics, including but not limited to annual OAPSA training by the Administrator.

5. Administrator has revised training materials and documentation of such, to better describe the contents of each training program moving forward. The Administrator will audit staff education on a monthly basis related to: education received, proper documentation of participation (signatures/dates) and course content to meet the 2600.65.g standards.

6. The above audit(s) will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented (- 04/11/2024)

65i - Training Record

4. 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

The record of training for staff person B did not include the dates of the following trainings:
Medication self-administration training
Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
Care for residents with dementia and cognitive impairments
Infection control
Personal care service needs of the resident
Safe management techniques
Care for residents with mental illness and mental retardation.
Emergency preparedness
Falls and accident prevention

65i - Training Record (continued)

The record of training for staff person C did not include the dates of the following trainings:
Medication self-administration training
Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
Care for residents with dementia and cognitive impairments
Infection control
Personal care service needs of the resident
Safe management techniques
Care for residents with mental illness and mental retardation.
Emergency preparedness
Resident Rights
Falls and accident prevention

The record of training for staff person D did not include the dates of the following trainings:

Medication self-administration training
Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan
Care for residents with dementia and cognitive impairments
Infection control
Personal care service needs of the resident
Safe management techniques
Care for residents with mental illness and mental retardation.
Emergency preparedness
Resident Rights
Falls and accident prevention

Plan of Correction ***Accept (█ - 03/08/2024)***

1. Employee B, C and D did in fact receive all of the required training for 2023. However, Employee(s) B, C and D, did not properly record the date in which the training topics list above were completed. Signatures of each training module are present but not properly dated. Administrator is able to verify participation for each staff member/training module.

2. This clerical error (missed date) was consistently an error across the majority of training modules as the form was revised and date was not included on the form in error. This has been corrected for the 2024 training/signature logs by Administrator.

3. All staff will be re-educated regarding the standards of 2600.65.i and the required documentation for each training: staff name, date, source, content, length of training and certificates (if received). As well as proper dating of the revised training log.

4. Administrator has revised the Record Keeping forms for all staff training to include all of the "record keeping standards" (including date of training completion). Administrator will audit all staff education on a monthly basis for proper documentation: staff name, date, source, content, length of course and copies of any certificates received.

65i - Training Record (continued)

5. The above audits will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented (- 04/11/2024)

101j7 - Lighting/Operable Lamp

5. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Bedroom 308 did not have a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept - 03/08/2024)***

1. Bedroom #308 had a bedside lamp present, however, the lamp was unplugged. Staff member plugged in the bedside lamp immediately upon discovery at time of survey. Bedside light is now functional.

2. Facility wide audit of bedside lighting completed by the Administrator on 02/21/2024 found no additional violations of this nature.

3. All Personal Care staff will be re-educated by the Administrator regarding the standards of 2600.101.j.7

4. Administrator will complete an audit of bedside lighting within each occupied room on a monthly basis to ensure on-going compliance.

5. Results of the above audit will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented - 04/11/2024)

103f - Refrigerator/Freezer Temps

6. 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 2/21/24 at 10:46AM the temperature of the kitchen refrigerator was 48 degrees Fahrenheit and at 2:21PM it was also 48 degrees Fahrenheit.

Plan of Correction ***Accept (- 03/08/2024)***

1. Repair technician was called immediately by Maintenance Director, upon determination that the kitchen refrigerator was not meeting required temperatures. Repair services were completed and temperature returned to below 40 degrees (F) by the end of the survey on 02/21/2024.

103f - Refrigerator/Freezer Temps (continued)

2. Temperature audit of all refrigerator/freezer temperatures throughout the kitchen/facility, revealed no additional issues with cooler/freezer temperatures.

3. Dietary Manager has re-educated Dietary personnel regarding 2600.102.f, including but not limited to; logging refrigerator temperatures daily and communicating temperatures out of range to the Maintenance staff immediately.

4. Dietary staff will record the refrigerator temperatures on a daily basis and logs/temperatures will be audited at least weekly by the Dietary Manager.

5. The above audits will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented (- 04/11/2024)

105g - Lint Removal and Duct Cleaning

7. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 10:23AM, there was an approximate 1 inch accumulation of lint in the lint trap of the SDCU dryer. There were no clothes in the dryer at the time.

Plan of Correction ***Accept (- 03/08/2024)***

1. The accumulated lint in the dryer on the SDC was removed by the Administrator at time of discovery, during survey.

2. No additional violations related to 2600.105.g were identified within the laundry care areas.

3. Environmental and Nursing staff will be re-educated regarding the standards of 2600.105.g by their respective departmental manager(s).

4. The Environmental Supervisor will audit compliance with lint removal from the dryer trap following each use, on a daily basis.

5. The above audit will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented - 04/11/2024)

187b - Date/Time of Medication Admin.

8. Requirements

2600.

187b Date/Time of Medication Admin. *(continued)*

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Ferosul 325, Take 1 tablet by mouth once daily, and Citalopram 10mg, Take1 tablet by mouth once daily. However, resident #1's February medication administration record does not include the initials of the staff person who administered these medications on February 18th 2024..

Plan of Correction ***Accept (- 03/08/2024)***

1. The incomplete Medication Administration Record (MAR) for Resident (#1) was the error of Staff Person (D). Staff person (D) verified that the medication was in fact administered for Resident (#1) on , as ordered and has properly signed (initial) the MAR.

2. Facility wide MAR audit completed by Administrator also found a "hole" (missing initials) for Resident (B). This error was also identified as an error by Staff Person (D) on The medication for Resident (B) was given by Staff Person (D) on 2/18/2024 and the MAR subsequently corrected. No additional MAR errors (holes) were found.

3. Staff Person (D) has been re educated regarding the standards of 2600,187.b, by the Administrator.

4. All Direct Care staff will be re educated regarding the standards of 2600.187.b by the Administrator.

5. The Administrator will audit the proper documentation required on the MAR (Initials/time) for all residents/staff members on a weekly basis.

6. The above audits will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented (- 04/11/2024)

227g -Support Plan Signatures

9. Requirements

2600.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #2 participated in the development of the support plan, dated however the resident did not sign the support plan nor does it indicate the resident's inability to participate.

Plan of Correction ***Accept (03/08/2024)***

1. Resident (#2) participated in the development of her Support Plan (August 2023). The Administrator will review the Support Plan again with Resident #2 and secure the residents signature/date.

2. The Administrator has reviewed the Support Plans of all existing residents (in house) and no further issues of this nature were identified.

227g Support Plan Signatures (continued)

3. Nursing Personnel will be re educated regarding the standards of 2600.227.g and the need for signatures of all individuals participating in the development of the Support Plan.

4. Administrator will complete an audit of required "participation signatures/dates" for each new/updated Support plan participation moving forward.

5. The above audits will be incorporated into the facility Quality Assurance and Continuous Quality Improvement program(s).

Licensee's Proposed Overall Completion Date: *03/29/2024*

Implemented [redacted] 04/11/2024)