

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395794	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2025
NAME OF PROVIDER OR SUPPLIER Saint John XXIII Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2250 Shenango Freeway Hermitage, PA 16148	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177</p> <p>Based on review of clinical records and the Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that the MDS assessment accurately reflected the status of one of 16 residents reviewed (Resident R2).</p> <p>Findings include:</p> <p>Review of MDS instructions for Section H Bladder and Bowel subsection H0300 Urinary Continence indicated that urinary continence is to be coded as not rated if during the seven-day look-back period the resident had an indwelling bladder catheter (tubing from the bladder to drain urine into the bag), condom catheter, ostomy, or no urine output for the entire seven days.</p> <p>Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included Benign Prostatic Hyperplasia (BPH - a noncancerous enlargement of the prostate gland, which can result in frequent urination, difficulty starting or stopping urination and a weak urine stream), depression (condition characterized by persistent feeling of sadness loss of interest in activities once enjoyed), gastro-esophageal reflux disease (a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure.</p> <p>Resident R2's clinical record revealed a physician's order dated 3/4/24, for an Indwelling Catheter.</p> <p>Resident R2's discharge MDS with Assessment Reference Date (ARD) of 5/30/24, admission MDS with ARD of 6/10/24, and quarterly MDS's with the ARD's of 9/10/24, 12/10/24, and 3/12/25, Subsection H0100 Appliances was coded as Indwelling Catheter and Subsection H0300 Urinary Continence was coded as Always Continent, although Resident R2 had an indwelling catheter for the entire seven-day look-back period.</p> <p>During an interview on 3/28/25, at 8:53 a.m. Registered Nurse Assessment Coordinator Employee E1 confirmed that the 5/30/24, 6/10/24, 9/10/24, 12/10/24 and 3/12/25, MDS's were coded inaccurately and urinary continence should have been coded as not rated for Resident R2.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.5(f)(ix) Medical records</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177</p> <p>Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for one of three residents reviewed (Resident R17).</p> <p>Findings include:</p> <p>Review of facility policy entitled Oxygen Administration dated 3/24/25, indicated to check and clean oxygen equipment at regular intervals.</p> <p>Resident R17's clinical record revealed an admitted [DATE], with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and high blood pressure.</p> <p>Resident R17's clinical record revealed a physician's order dated 9/17/24, for oxygen at 2 liter per min (lpm) via nasal cannula (a thin tube with two prongs that fit in a resident's nostrils to deliver oxygen) continuously, every shift for low oxygen level. Further review revealed a physician's order dated 5/31/21, that identified while on O2 (oxygen), change tubing, O2 humidifier bottle, clean concentrator and filter as needed.</p> <p>Observations on 3/25/25, at 11:40 a.m. and 3/27/25, at 10:18 a.m. revealed Resident R17 lying on his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 2 lpm via nasal cannula. Further observation of the concentrator filter on the back of the oxygen concentrator revealed a large amount of a gray fluffy substance covering the entire filter.</p> <p>During an interview on 3/27/25, at 10:18 a.m. the Director of Nursing confirmed that Resident R17's oxygen concentrator filter contained a large amount of gray dusty substance and should be cleaned.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177</p> <p>Based on review of facility policy and clinical records, and staff and resident interviews, it was determined that the facility failed to have complete and accurate documentation regarding indwelling catheter changes for one of two residents reviewed with an indwelling catheter (Resident R2).</p> <p>Findings include:</p> <p>Review of facility policy entitled Catheter Care dated 3/24/25, indicated under General Documentation Guidelines to document date, time, procedure, signature and title. And under General Infection Control Guidelines that all indwelling urinary catheters are to be changed every month unless otherwise ordered by the physician.</p> <p>Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included Benign Prostatic Hyperplasia (BPH - a noncancerous enlargement of the prostate gland, which can result in frequent urination, difficulty starting or stopping urination and a weak urine stream), depression (condition characterized by persistent feeling of sadness loss of interest in activities once enjoyed), gastro-esophageal reflux disease (a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure.</p> <p>Resident R2's clinical record revealed that on 11/5/24, their physician ordered an indwelling catheter change to be completed monthly and as needed.</p> <p>Review of Resident R2's Treatment Administration Records (TAR) for January 2025 and February 2025, lacked documentation indicating the catheter change was completed per physician's orders.</p> <p>During an interview on 3/25/25, at 12:00 p.m. Resident R2 stated the facility changes his indwelling catheter on a monthly basis.</p> <p>During an interview on 3/28/25, at 9:46 am. the Director of Nursing confirmed that Resident R2's treatment records did not have complete documentation regarding indwelling catheter changes.</p> <p>28 Pa. Code 211.5(f)(ii)(iii)(viii)(ix) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		