



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
Norristown State Hospital  
1001 Sterigere Street  
Bldg 2 Rm. 161  
Norristown, Pennsylvania 19401

ADULT RESIDENTIAL LICENSING

1-866-711-4115  
610-270-1137

**CERTIFIED MAIL – RETURN RECEIPT REQUESTED**  
**Mailing Date: March 22, 2011**

Dr. Robert Griffith, President  
Woods Services, Inc  
D. Cerra-TYL, 469 Maple Avenue  
Langhorne, Pennsylvania 19047

RE: Beechwood Center 4  
586 Beechwood Circle  
Langhorne, Pennsylvania 19047

Dear Dr. Griffith:

As a result of the Department of Public Welfare's licensing inspection on November 5, 2010 of the above personal care home, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed Violation Report were found.

All violations specified on the enclosed Violation Report must be corrected by the dates specified on the Violation Report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained. As soon as each violation is corrected, notify the Department's Regional Office of Adult Residential Licensing so that compliance can be verified.

Sincerely,

A handwritten signature in black ink that reads "Chevon Mitchell" with a stylized flourish at the end.

Chevon Mitchell  
Regional Licensing Administrator

Enclosure(s)  
Violation Report

VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600

NAME AND ADDRESS OF PERSONAL CARE HOME BEECHWOOD CENTER 4, 586 BEECHWOOD CIRCLE LANGHORNE, PA 19047		CURRENT LICENSE NUMBER 129660	
INSPECTION DATES (Include all dates of the inspection) 11/05/2010		REGIONAL REPRESENTATIVE Patricia Adams, Lori Knockstead	
PRINTED NAME AND TITLE OF LEGAL ENTITY REPRESENTATIVE SIGNING PLAN OF CORRECTION (Required on FIRST PAGE only unless multiple representatives produce the plan) <i>PAT BOYLE DIRECTOR QUALITY IMPROVEMENT</i>			
SIGNATURE OF LEGAL ENTITY <i>Pat Boyle, Director Quality Improvement</i>		DATE <i>2/15/11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>Cherise Mitchell</i>
			DATE <i>3/18/11</i>

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
186b Prescription medications shall be used only by the resident for whom the prescription was prescribed.	On 10/23/10, staff person B discovered the blister card of medication containing Provigil 100 mg had a pouch for the next dose taped closed. Staff person B skipped the taped dosage and administered the next correctly package dose. The taped dose was later identified by the pharmacy as generic Risperidone 1 mg tablet and not Provigil. The home was unable to determine the source of the Risperidone. Staff person A admitted to replacing the Provigil with Risperidone but did not disclose the source of the replaced medication.	<i>10/25/10</i> <i>12/5/10</i>	<i>Staff person A no longer works at our facility.</i> <i>Staff will report immediately any signs of tampering upon discovery to nursing supervisor. (see attached)</i>	<i>Steps have been taken to correct violation; full compliance is not verifiable</i> Date _____ Initials (DPW) _____

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SIGNATURE OF LEGAL ENTITY <i>Passage Director Quality Improvement</i>	DATE 3/16/11	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>Cheryl Mitchell</i>	DATE 3/18/11

REGULATION 55 Pa.Code §2600	VIOLATION	DATE BY WHICH CORRECTION WILL BE COMPLETED	PLAN OF CORRECTION (include a step-by-step plan to correct the specific violation, as well as a plan to assure the violation does not recur)	DATE COMPLIANCE VERIFIED BY
185b At a minimum, the procedures must include: (1) Documentation of the receipt of controlled substances and prescription medications. (2) A process to investigate and account for missing medications and medication errors. (3) Limited access to medication storage areas. (4) Documentation of the administration of prescription medications, OTC medications and CAM for residents who receive	On 4/28/10 and 5/26/10 at 8:00 pm, 6/13/10 and 6/20/10 at 8:00 am, staff person A wasted resident #1's Provigil 100 mg; on 9/18/10 at 9:00 pm, staff person A wasted 3 doses of resident #2's Provigil 100 mg without following the home's procedure for controlled drugs. The home's procedures state "If a dose is removed from the punch card and is refused, it should be destroyed in the presence of two licensed personnel and documented on the MAR and the individual Narcotic Record with both persons signature." Staff person A wasted resident's #1 Provigil without a witness and the Individual Narcotic Record was not countersigned by a second licensed person after the dose was refused.	10/25/10  12/8/10  12/10	<i>Staff person A no longer works at our facility.</i>  <i>Memo given to staff regarding controlled medication discrepancies. (see attached)</i>  <i>The nursing supervisor and residential administrators conduct random, monthly checks of controlled medication records.</i>  <i>The nursing supervisor reviews all controlled medication records for all 7 licensed facilities at the end of the month before filing occurs.</i>	<i>Steps have been taken to correct violation; full compliance is not verifiable</i> Date _____ Initials (DPW) _____

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SIGNATURE OF LEGAL ENTITY <i>Pat Boyle, Director Quality Improvement</i>	DATE <i>3/16/11</i>	REGIONAL LICENSING APPROVAL OF PLAN OF CORRECTION <i>Cherone Mitchell</i>	DATE <i>3/18/11</i>

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medication administration services or assistance with self-administration. This requirement does not apply to a resident who self-administers medication without the assistance of a staff person and stores the medication in his room.		<i>1/27/11</i>	<i>A committee has been formed and meets monthly to review/analyze data.</i>	

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187d The home shall follow the directions of the prescriber.	<ul style="list-style-type: none"> <li>- Staff person A crushed resident #1's Provigil 100 mg on 6/13/10 and 6/20/10 at 8:00 am and on 5/26/10 at 8:00 pm. There was no order for Provigil to be administered crushed.</li> <li>- On 4/28/10 and 5/26/10 at 8:00 pm, staff person A poured Provigil 100 mg for administration to resident #1; 12 hours after the prescribed time of 8:00 am.</li> <li>- On 9/16/10 at 9:00 pm, staff person A poured 3 doses of Provigil 100 mg for administration to resident #2; 13 hours after the prescribed time. The prescription label states "1/2 tablet orally every morning at 8 am".</li> </ul>	<p>10/25/10</p> <p>11/29/10</p> <p>12/10</p>	<p><i>Staff person A no longer works at our facility.</i></p> <p><i>Staff were given a copy of the Medication Procedure Manual to review so that proper protocols are followed. (see attached)</i></p> <p><i>The nursing supervisor now conducts random monthly checks of controlled medication records and MAR's to identify any concerns and appropriate action will be taken.</i></p>	<p>Steps have been taken to correct violation; full compliance is not verifiable</p> <p><i>[Signature]</i> Initials (DPW)</p> <p><i>[Signature]</i> Date</p>