



pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUL 23 2015

Mr. Mark Pile, CEO
Diakon Lutheran Social Ministries
798 Hausman Road, Suite 300
Allentown, Pennsylvania 18104

RE: The Buehrle Center
One South Home Avenue
Topton, Pennsylvania 19562
License #: 214960

Dear Mr. Pile:

As a result of the Department of Human Services' licensing inspection on May 7, 2015 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed License Inspection Summary were found.

All violations specified on the enclosed License Inspection Summary must be corrected by the dates specified on the License Inspection Summary and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

Your regular license for the period July 24, 2015 to July 24, 2016 was issued on May 1, 2015. Your regular license remains in good standing.

Sincerely,

Matthew J. Jones
Director

Enclosure
License Inspection Summary

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa. Code §2600
 2600.65(g) - Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
 (1) Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert.
 (2) Emergency preparedness procedures and recognition and response to crises and emergency situations.
 (3) Resident rights.
 (4) The Older Adult Protective Services Act (35 P. S. §§ 10225.101-10225.5102).
 (5) Falls and accident prevention.
 (6) New population groups that are being served at the home that were not previously served, if applicable.

2a. DESCRIPTION OF VIOLATION
 Direct care staff person A hired 12/9/13 did not receive training in fire safety for training year 2014.
 Contract ancillary staff person B hired 9/16/10 did not receive training in emergency preparedness and falls and accident prevention for training year 2014.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

It is important for direct care staff and ancillary staff to be trained annually in fire safety in order to respond appropriately to an emergency. Ancillary staff will also receive training as outlined in regulation 2600.65 (g) to ensure staff working in the home are aware of the reporting requirements. Immediately direct care staff and ancillary staff will be trained on those areas identified above.

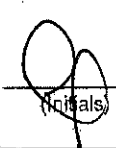
A monthly review of staff training will be done by the Unit Manager. Tracking will be added to our QAPI report. Staff identified as not completing the required training will be given the opportunity to attend training on multiple dates. *Employees who missed prior training will have 2 fire training sessions the following year. OO*
 Reviews will begin in June 2015 and be ongoing. The Administrator will monitor to ensure *3/20/15* compliance.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date) The above plan of correction was approved by  (Initials)	Plan of correction implementation status as of <u>7/20/15</u> (Date) <input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented
---	--

Violation Report: 21496 - 06/07/2016 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION-55 Pa.Code §2600
 2600.82(a) - Poisonous materials shall be stored in their original, labeled containers.

2a. DESCRIPTION OF VIOLATION

3 unlabeled bottles with steri-fab written on the bottle were located in the nursing office. The original product labeling was not attached to the bottle.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The three unlabeled bottles with steri-fab were removed immediately from the nursing office.

Bottles need to be labeled with the manufacturer's label to prevent the possible misuse and / or harm to staff or residents.

Bottles or containers brought to the unit will be checked for the manufacturer's label by the charge nurse on the unit. Any bottle or container that does not have the manufacturer's label will not be accepted on the unit.

A weekly inspection will be done by the Unit Manager to ensure there are no bottles or container on the unit that do not have a manufacturer's label.

The Administrator will conduct random checks on the unit for any bottles or containers that do not have the manufacturer's label.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of 7/20/15
 (Date)

Plan of correction implementation status as of 7/20/15
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

The above plan of correction was approved by *Op*
 (Initials)

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa. Code §2600
 2600.91 - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

2a. DESCRIPTION OF VIOLATION
 The telephone located in room #14 did not have emergency numbers posted near the phone.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

In the event of an emergency it is important that each phone with an outside line have an emergency card with the telephone numbers of the: nearest hospital, police department, ambulance, poison control, local emergency management and personal care home complaint hotline so that both staff and resident have quick access in the event of an emergency.

An emergency card was placed in room #14 and an inspection of each room was conducted by the Unit Manager to ensure compliance with regulation 2600.91

Direct care staff have been instructed to check for emergency cards in the resident's room when providing care or administering medication.

At the Resident Forum, residents will be reminded of the importance of the emergency card near their phone and not to remove these cards.

Monthly checks will be done by the Unit Manager for the emergency card to be near each phone with access to an outside line.

Random checks will be conducted by the Administrator.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <i>7/20/15</i> (Date)	Plan of correction implementation status as of <i>7/20/15</i> (Date)
The above plan of correction was approved by <i>[Signature]</i> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION-55-Pa.Code-§2600
 2600.124 - The home shall notify the local fire department in writing of the address of the home, location of the bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

2a. DESCRIPTION OF VIOLATION
 The facility currently has 28 residents with mobility needs that would require assistance to evacuate the facility in the event of an emergency. The facility has not notified the local fire department of a general description of the mobility needs of the residents as required.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

In the event of a fire or emergency it is important for the Fire Department to know the floor plan and the residents who would need assistance in the event of an emergency.

The Plan was sent to the local fire department with the location of the Secure Dementia Unit and also the names and room numbers of those residents who would need assistance in the event of an emergency. Please see attachment A-1,2,3,4

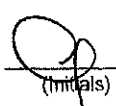
The Administrator will be responsible for notifying the Fire Department whenever there is a change in status of a resident who may need assistance evacuating the building or and admission who may need assistance with the evacuation. Please see attachment B-1,2

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa. Code §2600
 2600.132(e) - A fire drill shall be held during sleeping hours once every 6 months.

2a. DESCRIPTION OF VIOLATION
 Department Representatives interviewed staff person C who is the Administrator. Based upon this interview it was determined the facility's sleeping hours in the personal care side of the facility are from 9:00pm to 6:00am. Department Representatives reviewed the facility's fire drill log. It was determined the facility last held a fire drill during sleeping hours on 5/15/14 at 5:55am.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Fired Drill held on 08/27/14 was at 6:18 AM and was outside the stated sleeping hours for the Personal Care side of the facility.

Regulation 2600.132 (a) was reviewed on 05/07/15 with the staff member who is responsible for conducting the fire drills in the Personal Care side of the facility.

The Administrator will monitor the Fire Log weekly to ensure that a fire drill will be held every six months during resident sleeping hours. If the fire drill is held outside the sleeping hours another Fire Drill will be conducted to ensure compliance with the regulation.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative (Required on EVERY Page)	<i>Michelle P. Olivier</i>
--	----------------------------

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Michelle P. Olivier, Admin</i>	<i>06-18-15</i>

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u><i>MP</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

~~1. REGULATION 55 Pa. Code §2600~~
 144(c)(2) Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

2a. DESCRIPTION OF VIOLATION
 2 cushions were located in the home's designated smoking area. The labels on the cushions noted care should be exercised near open flames or near burning cigarettes.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The two cushions were removed immediately from the smoking area.

To reduce the risk of fire from residents who smoke in the designated area all furniture will be fire resistant.

The furniture in the smoking area is made of fire resistant material as outlined in regulation 2600.144 (c)

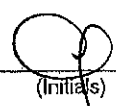
The Administrator will make weekly rounds to ensure there are no cushion placed in the designated area unless they meet the requirements outlined by the regulation. When the Administrator is away for a period of time the Unit Manager will make the rounds to ensure compliance.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55-Pa.Code §2600-2600.183(d) - Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

2a. DESCRIPTION OF VIOLATION
 Resident #1, #2 & #3 are prescribed an Advair Diskus. These medication containers were not dated when opened. The medication manufacturer's instructions indicate to discard this medication 30 days after removing the medication from the foil packaging.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

It is important that the date medication is opened and the manufacturer's instructions indicate that the medication be discarded after 30 days that a date be placed on the medication container. This will enable staff to know when to discard the medication.

Staff were re-educated on the importance of dating medications when the instructions indicate the medication is to be discarded after a set number of days.

The Unit Manager will monitor medications that require a date to determine when to discard the medication on a monthly basis.

The monitoring will be added to the facility QAPI and reviewed by the Administrator monthly. If there is 100% compliance for 6 months, the monitoring will be done quarterly on the QAPI.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u><i>[Signature]</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. **REGULATION 55 Pa. Code §2600**
 2600.183(e) - Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

2a. **DESCRIPTION OF VIOLATION**
 Department Representatives observed a loose pill at the bottom of the medication cart drawer. The pill had an "A" inscribed on one side and an "11" inscribed on the other side. It was unable to be determined which resident the pill was prescribed to. The facility is responsible to safely and properly store and account for resident medications.

3. **PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

During the annual inspection one pill was found on the bottom of one of the medication carts and discarded.

Staff have been instructed to check the medication carts once during each shift to ensure that there are no loose pills on the bottom of the cart.

Staff have also been instructed to exercise caution when removing and replacing medication cards in the cart to prevent accidental tearing of medication packages.

Staff will be reminded in our monthly staff meeting the importance of careful handling of medication cards and to check the medication carts during their shift for loose pills.

The Unit Manager and the Administrator will conduct random checks on the medication carts to ensure that there are no loose pills on the bottom of the carts.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u><i>CO</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa. Code §2600
 2600.184(a) - The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
 (1) The resident's name.
 (2) The name of the medication.
 (3) The date the prescription was issued.
 (4) The prescribed dosage and instructions for administration.
 (5) The name and title of the prescriber.

2a. DESCRIPTION OF VIOLATION
 Resident #4's Lantus solostar pen did not have a pharmacy label attached.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Medications require a pharmacy label to prevent medication being administered to the wrong resident.

A label was obtained for the Lantus Solostar pen and placed on the pen.

The Unit Manager will do three random checks monthly to monitor that all medications have a pharmacy label.

This will be added to our QAPI monthly report for 6 months. When there is 100% compliance for 6 consecutive months the QAPI monitoring will be done quarterly.

The Administrator will monitor the QAPI report monthly.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative (Required on EVERY Page)	<i>Michelle P. Olivier</i>
--	----------------------------

Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
<i>Michelle P. Olivier, Admin</i>	<i>06-18-15</i>

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u><i>Op</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55-Pa. Code §2600
 2600.184(b) - If the OTC medications and CAM belong to the resident, they shall be identified with the resident's name.

2a. DESCRIPTION OF VIOLATION
 Resident #4's Res Q and enteric coated aspirin was not labeled with the resident's name.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The enteric coated aspirin belonging to Resident #4 was labeled immediately.

In order to properly identify which medication belongs to a resident, the medication will be identifies with the resident's name.

Staff were instructed on the importance of labeling resident's OTC medication and CAM with the resident's name.

The Unit Manager and the Administrator will do random checks monthly to ensure all OTC medications and CAM's are labeled with the resident's name to whom they belong.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michelle P. Olivier</i>	Date <i>06-18-15</i>
--	----------------------

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u><i>PO</i></u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

~~1. REGULATION 55-Pa.Code §2600~~
 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.

2a. DESCRIPTION OF VIOLATION
 The homes narcotic policy notes the off-going and on coming staff to sign the controlled drug shift count record to verify the remaining narcotic count. The 3p-11p off going person did not sign the log on 4/1/15. The 7a-3p off going person did not sign the log on 5/3/15. The 7a-3p on coming person did not sign the log on 5/5 and 5/6/15.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

The Facility Policy requires that the signature of the on coming staff and the off going staff be on the narcotic log to verify the remaining narcotic count.

Staff were re-educated on the facility policy regarding signatures required by the on coming staff and the off going staff on the narcotic log for the narcotic count.

The Unit Manager will check the narcotic count log twice a month to ensure staff are in compliance with the facility policy.

This will be tracked on the QAPI for 3 consecutive months. Where there is 100% compliance for 3 months then the tracking will be done quarterly.


This tracking will be monitored by the Administrator to ensure compliance.

Repeat Violation: Yes	Date(s) of Previous Violation(s):	05/07/2014
-----------------------	-----------------------------------	------------

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michelle P. Olivier, Admin</i>	Date <i>06-18-15</i>
---	----------------------

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PGH Name: THE BUEHRLE CENTER

1. REGULATION 55-Pa.Code §2600

2600.187(a) - A medication record shall be kept to include the following for each resident for whom medications are administered:

- (1) Resident's name.
- (2) Drug allergies.
- (3) Name of medication.
- (4) Strength.
- (5) Dosage form.
- (6) Dose.
- (7) Route of administration.
- (8) Frequency of administration.
- (9) Administration times.
- (10) Duration of therapy, if applicable.
- (11) Special precautions, if applicable.
- (12) Diagnosis or purpose for the medication, including pro re nata (PRN).
- (13) Date and time of medication administration.
- (14) Name and initials of the staff person administering the medication.

2a. DESCRIPTION OF VIOLATION

Resident #5 is prescribed to have blood glucose readings twice daily at 7:00am and 4:30pm. Department Representatives observed the resident's glucometer and the resident's Medication Administration Record (MAR). The following discrepancies were noted: On 5/5/15 at 6:40am the resident's blood glucose reading was taken; The glucometer reading indicates the resident's blood glucose was 153. The resident's MAR indicates the resident's blood sugar reading was 81.

Resident #6 is prescribed blood sugar readings twice daily. On 5/2/15 the glucometer read 216 but the MAR noted 217.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident # 5 had an additional glucometer reading on 5/5/15 due to symptoms the resident was having. The additional reading was not documented in the MAR.

Staff were educated on the importance to carefully document all glucometer readings in the MAR.

Resident #6 - staff were educated on the need to transfer readings on the glucometer accurately to the MAR.

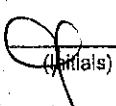
The 11-7 shift will do a weekly comparison of glucometer readings to the MAR. The Unit Manager will address any discrepancy with staff. The Administrator will monitor compliance on an ongoing basis.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55-Pa.Code §2600
 2600.187(d) - The home shall follow the directions of the prescriber.

2a. DESCRIPTION OF VIOLATION
 Resident #6 is prescribed to have blood glucose readings twice daily at 7:00am and 4:30pm. Department Representatives observed the resident's glucometer. It was determined on the following days the resident's blood sugar reading was not taken at the prescribed time of 7:00am.
 5/3/15 at 5:44am
 5/6/15 at 4:58am
 5/7/15 at 5:18am

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

To ensure proper dispensation of medication, staff will follow the guidelines as ordered by the physician.

Staff have been instructed to follow orders as they are written by the physician. This will be discussed at our monthly staff meetings.

The Unit Manager will check the MAR monthly to ensure staff are following physician orders.

We will add this to the QAPI monitoring for 3 months. If there is 100% compliance for 3 consecutive months the QAPI monitoring will be done quarterly.

Random checks will be done by the Administrator to ensure compliance.

Repeat Violation: No Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier, Admin* Date *06-18-15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by <u>Op</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented


Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa. Code §2600
 2600.231(b) - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner, documented on a form provided by the Department, within 60 days prior to admission. Documentation shall include the resident's diagnosis of Alzheimer's disease or other dementia and the need for the resident to be served in a secured dementia care unit.

2a. DESCRIPTION OF VIOLATION
 Resident #1 was transferred to the facility's secured dementia care unit on 8/4/14. The resident's medical evaluation completed on 7/24/14 does not indicate the resident has a diagnosis of Dementia or Alzheimer's related disease.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

Resident #1 was seen by their Primary Physician on 7/24/15 and documentation on the Physician's Progress Notes stated: SDAT (Senile Dementia Alzheimer Type). However this was not documented on the DME.

Physician's and those qualified to fill out the DME will be informed that residents who are admitted to the SDU must show a diagnosis of Alzheimer's disease or other dementia on the DME. Any updates to the DME will be initiated or signed by the person making the update, as well as the date. 
 The Unit Manager will review all admissions to the SDU for proper documentation on the DME.

7/20/15


The Administrator will also check all admission to the SDU to ensure that the DME, Assessment and Support Plans have proper documentation.

Repeat Violation: No	Date(s) of Previous Violation(s):		
----------------------	-----------------------------------	--	--

Signature of Legal Entity Representative
 (Required on EVERY Page) *Michelle P. Olivier*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Michelle P. Olivier, Admin</i>	Date <i>06/18/15</i>
---	----------------------

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <u>7/20/15</u> (Date)	Plan of correction implementation status as of <u>7/20/15</u> (Date)
The above plan of correction was approved by  (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 21496 - 05/07/2015 - Novak, Ryan
 PCH Name: THE BUEHRLE CENTER

1. REGULATION 55 Pa.Code §2600

2600.233(c) - If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

2a. DESCRIPTION OF VIOLATION

Department Representatives observed the facility's exterior courtyard of the secured dementia care unit. The gate of the courtyard is secured by magnetic locking mechanism. The directions or code for the magnetic locking mechanism is not posted on or near the device.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)

Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

To enable those who do not require a SDU to be able to exit the SDU at will, a posting containing directions to exit the unit will be placed near the exiting device.

Instructions to exit the facility exterior courtyard of the SDU has been posted near the keypad.

To ensure continual compliance with Regulation 2600.233 (c) the Administrator will check weekly all exits in the SDU to ensure they have instructions to exit the unit near the operating device. If the Administrator is away for a period of time the Unit Manager will check all exits in the SDU for instructions posted near the exit operating device.

Repeat Violation: No

Date(s) of Previous Violation(s):

Signature of Legal Entity Representative
 (Required on EVERY Page)

Michelle P. Olivier

Printed Name and Title of Legal Entity Representative
 (Required on EVERY Page)

Michelle P. Olivier Admin

Date *06/18/15*

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of

7/20/15
 (Date)

Plan of correction implementation status as of

7/20/15
 (Date)

The above plan of correction was approved by

OP
 (Initials)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented