



pennsylvania
DEPARTMENT OF HUMAN SERVICES

JUN 0 1 2016

Mr. Michael B. Laign, President/CEO
Holy Redeemer Health System
1616 Huntingdon Pike
Meadowbrook, Pennsylvania 19046

RE: Holy Redeemer St. Joseph Manor
License #: 127940

Dear Mr. Laign:

As a result of the Department of Human Services' annual licensing inspection on April 25, 2016 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.

Sincerely,

A handwritten signature in black ink, appearing to read "Jay Bausch".

Jay Bausch
Deputy Secretary

Enclosure
License Inspection Summary

Violation Report: 12794 - 04/25/2016 - Keppel, Autumn
 PCH Name: HOLY REDEEMER ST JOSEPH MANOR

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

2a. DESCRIPTION OF VIOLATION
 Resident #1 has an order for their blood sugar to be checked before breakfast and at bedtime. On 4/11/16, there was no reading found in the resident's glucometer for the bedtime check.

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.

Corrective Action:

The two staff involved in checking the missed blood sugar on 4/11/2016 were educated on Regulation 2600.187(d) by the Nurse Manager on 4/29/2016 and 5/3/2016.
 (see attached Education)

To Ensure this Violation Does Not Recur:

1. All staff involved in checking blood sugars (accuchecks) will be educated on Regulation 2600.187(d)
 (Responsible Staff: Nurse Manager) (Completion Date: 5/31/2016)
2. Random audits will be completed to assure that blood sugars (accuchecks) are completed as prescribed.
 (Responsible Staff: Nurse Manager/Designee) (Completion Date: 5/31/2016 & Ongoing)

Repeat Violation: Yes	Date(s) of Previous Violation(s):	09/29/2015	
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Signature of Legal Entity Representative
 (Required on EVERY Page) *Cecile F. Shocket*

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <i>Cecile F. Shocket</i>	Date <i>5/10/16</i>
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DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!

The above plan of correction is approved as of <i>5/13/16</i> (Date)	Plan of correction implementation status as of <i>5/13/16</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

Holy Redeemer St. Joseph Manor Personal Care
License #: 127940

Education on Regulation 2600.187d

Date: 4/26/2016

Education Provided by: [REDACTED], LPN, Nurse Manager

VIOLATION: Regulation 187.d- the home shall follow the directions of the prescriber.

On the evening of 4/11/2016, 2200hr, a blood sugar was scheduled to be checked. On review it was found that the blood sugar had not been checked as prescribed. There was no documentation on the medication administration record as to why the treatment was missed.

Plan of correction:

- Staff to determine if a treatment is to be completed for their designated shift. Communication between staff will occur to determine who is responsible to complete the treatment.
- Complete all treatments per the prescriber's orders. Initial completion of treatment.
- Follow special instructions the prescriber ordered surrounding a refusal or LOA of a treatment.
- Documentation shall be entered on the back side of the medication administration record describing the circumstances around a missed treatment and plan of action if needed.
- At time of missed treatment you are to communicate to team leader, oncoming shift or prescribing doctor, if ordered, any missed treatments due to the resident not being on unit or a refusal.

*Anytime a medication or treatment is missed it must be documented on the back of the medication administration record. This communication is essential in determining why a treatment was missed. This information will assist the staff and/or doctor to determine if the prescribed order needs adjusting to accommodate the resident.