pennsylvania
DEPARTMENT OF HUMAN SERVICES

August 1, 2019

Mr. Scott D. Habecker
Executive Vice-President
Chief Operating Officer/Chief Financial Officer
Diakon Lutheran Social Ministries
One South Home Avenue
Topton, Pennsylvania 19562

RE: The Buehrle Center
License #: 214960

Dear Mr. Habecker:

As a result of the Department's Bureau of Human Services Licensing annual inspection on April 18, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations 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.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: *THE BUEHRLE CENTER* **License Number:** *214960*
Address: *ONE SOUTH HOME AVENUE, TOPTON, PA 19562*
County: *BERKS* **Region:** *NORTHEAST*

Administrator

Name: *Mark Heil* **Phone:** *6106821400* **Email:** *heilm@DIAKON.ORG*

Legal Entity

Name: *DIAKON LUTHERAN SOCIAL MINISTRIES*
Address: *ONE SOUTH HOME AVENUE, PA, 19562*

Certificate(s) of Occupancy

Type: *Other* **Date:** *07/02/2018* **Issued By:** *Dept. of Health*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *126* **Waking Staff:** *95*

Inspection

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

Inspection Dates and Department Personnel

04/18/2019 - On-Site: Jason Harvey, Gearld Dumas

Resident Demographic Data as of Inspection Date

General Information

License Capacity: *92* **Residents Served:** *76*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *1st Floor* **Capacity:** *26* **Residents Served:** *25*

Hospice

Current Residents: *2*

Number of Residents Who

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *76*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability:** *0*
Have Mobility Need: *50* **Have Physical Disability:** *0*

2 Hours/Day

Regulations

2600.
57.c. Direct care staff persons shall be available to provide at least 2 hours per day of personal care services to each resident who has mobility needs.

Description of Violation

On 4/5/19, 4/6/19 and 4/7/19, there were 74 residents in the home, including 54 residents with mobility needs, requiring a total minimum of 128 hours of direct care service. On 4/5/19, only 121.75 hours of direct care staffing was provided, 4/6/19, only 127 hours of direct care staffing was provided and on 4/7/19, only 123 hours of direct care staffing was provided.

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.)

57c - Staff call-outs were a primary factor these dates. Attendance Policy and coverage procedure for when a call out is received have been reviewed with staff during staff meetings.
Administrator, Clinical Services Manager and PC Scheduler will monitor daily scheduled hours to ensure the hours of need are met.

Legal Entity Representative

[signature] Marc Heil PCHA 6/26/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX

The above plan of correction is approved as of 6-27-19 (Date)

Plan of correction implementation status as of 6-27-19 (Date)

- [ ] Fully Implemented
- [x] Partially Implemented - Adequate Progress
- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

The above plan of correction was approved by AG (Initials)

57d - Waking Hours

Regulations

2600.
57.d. At least 75% of the personal care service hours specified in subsections (b) and (c) shall be available during waking hours.

Description of Violation

On 4/5/19, 4/6/19 and 4/7/19, there were 74 residents in the home, including 54 residents with mobility needs, requiring a total minimum of 128 hours of direct care service and 96 hours during waking hours required. On 4/5/19, only 88.5 hours of direct care staffing was provided during waking hours, 4/6/19, only 88.5 hours of direct care staffing was provided during waking hours and on 4/7/19, only 88.5 hours of direct care staffing was provided during waking hours.

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.)

57d - Staff call-outs were a primary factor these dates. Attendance Policy and coverage procedure for when a call out is received have been reviewed with staff during staff meetings.
Administrator, Clinical Services Manager and PC Scheduler will monitor daily scheduled hours to ensure that 75% of scheduled hours are during waking hours.

Legal Entity Representative

Signature

Marc Heil PCHA 6/26/19
Printed Name and Title Date

DEPARTMENT USE ONLY

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Plan of correction implementation status as of 6-27-19 (Date)

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- ☐ Not Implemented

60a - Staff/Support Plan

Regulations

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home's letter from Fire Chief of Topton Fire Department dated 6/29/18 determines that residents should be evacuated from the home within 6 minutes. On 4/5/19, there was 74 residents present in the home and 54 residents with mobility needs.

25 of these residents reside in the secured dementia unit and 59 of these residents reside in the personal care wing of the home.

Of the residents that reside in personal care wing of the home, there are the following:

• 26 residents that require 2:1 physical assistance to transfer from their beds or chairs in order to evacuate in an emergency.

• 22 residents that require 1:1 physical assistance from staff to evacuate the home in an emergency.

Of the residents that reside in personal care SDCU wing of the home, there are the following:

• 25 residents that require verbal queuing assistance from staff to evacuate the home in an emergency.

On 4/5/19 from 11:00pm-7:00am, there were 3 staff persons working in the home. Three staff persons cannot evacuate all residents safely based on the residents mobility needs.

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.)

60.a – The Annual Fire Inspection was completed on 6/20/19 by Fire Chief Jason Robinson of the Topton Volunteer Fire Company with the determination of the safe evacuation time of 10 minutes.

Post fire drill reviews will be conducted within 48 hours following drills and will consist of Administrator, Clinical Services Manager, Fire Drill Supervisor and involved shift supervisor (LPN or Med Tech). The purpose of this review will be to identify staff educational needs and resident mobility status changes.

Additionally, all residents will be re-evaluated regarding their current mobility status in order to ensure they are correctly designated as mobile or immobile. This re-evaluation will be completed no later than 8/31/19.

Administrator will monitor to ensure continued compliance.

Legal Entity Representative

The Administrator will update the NE Regional Office on 9-2-19 regarding the status of post fire drill reviews and findings, as well as the home's fire drill logs and a list of residsents with mobility needs and the assistance needed for a safe evacuation. This will be done via fax or e-mail to Anne Graziano and Bob Bisignani of the NE REgional Office. 7-9-19

Signature | Marc Heil AG 7/8/19 (Printed Name and Title / Date)

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 7-9-19 (Date)

The above plan of correction was approved by AG (Initials)

Plan of correction implementation status as of 7-9-19 (Date)

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- ☐ Not Implemented

64c - Annual training

Regulations

2600.
64.c. An administrator shall have at least 24 hours of annual training relating to the job duties. The Department-approved administrator training course specified in subsection (a) fulfills the annual training requirement for the first year.

Description of Violation

Staff person A, the home's administrator, completed only 18 hours of Department-approved training in training year 2018.

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.)

64c – Administrator has been educated that only 12 hours of the 24 hours of annual training may be completed online. 18 hours were completed online for training year 2018.
Administrator will ensure and monitor adherence to this policy going forward and will complete the missing 6 hours of training in addition to the normally required 24 hours – equaling 30 hours of training in the 2019 training year.

The Administrator will clearly organize and tag training documentation so it is clear when the 24 hours for Training Year 2018's requirements have been satisfied and the subsequent trainings will be credited to Training Year 2019. The Administrator will retain these documents to evidence compliance. 6-27-19

Legal Entity Representative

Signature

Marc Heil PCHA — Printed Name and Title

6/26/19 — Date

DEPARTMENT USE ONLY ALLOWS

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65d.3 Initial Direct Care Training

Regulations

2600.
65.d.3. Initial direct care staff person training to include the following:

Description of Violation

Direct care staff person B, hired on 1/7/19 and direct care staff person C, hired on 1/28/19 began providing unsupervised ADL services. However, the staff persons did not complete the following initial direct care staff person training:

vii. Nutrition, food handling and sanitation.

viii. Recreation, socialization, community resources, social services and activities in the community.

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.)

65d3 – The topics of Nutrition, Food Handling and Sanitation, as well as, Recreation, Socialization, Community Resources, Social Services and Activities in the Community have been added to the orientation curriculum for new hires to be completed prior to providing unsupervised ADL services. Administrator and Clinical Services Manager will monitor compliance.

The Administrator will ensure that Employees B and C have completed their initial components of Direct Care Training. The Administrator will ensure that the documents are included in the employee file (or where training ddocuments are stored) to evidence compiance. 6-27-19

Legal Entity Representative

Signature: [signature]

Printed Name and Title: Marc Heil PCHA

Date: 6/26/19

DEPARTMENT USE ONLY - HOME SHOULD NOT WRITE IN THIS BOX

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The above plan of correction was approved by AG (Initials)

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- [ ] Fully Implemented
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- [ ] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

87 - Lighting

Regulations

2600.

87. Lighting - The home's hallways, interior stairs, outside steps, outside doorways, porches, ramps, evacuation routes, outside walkways and fire escapes shall be lighted and marked to ensure that residents, including those with vision impairments, can safely move through the home and safely evacuate.

Description of Violation

At approximately 10:15 a.m., during the walk through of the facility, Department Representative observed insufficient lighting from the Buehrle Center Team Conference Room exit along the grassy egress path, to the external fire meeting location. The lack of lighting posed a potential safety hazard for both residents and staff attempting to evacuate the building at night, in the event of a fire or emergency.

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.)

87 – Cost Quotes are being obtained for installation of electric source and motion-activated lighting fixture to illuminate the grassy egress path in the event of a nighttime evacuation. The completion of the project will be expedited once the approved quote is received.
Maintenance Director and Administrator will monitor for compliance.

The Administrator will make every effort to remedy this violation within 45 days of receipt of the approved Plan of Correction. Photos and a completed work order with proof of payment will be sent to the NE Regional Office within this 45 day time frame. 7-24-19

AG

Legal Entity Representative

Signature

Marc Heil PCHA 6/26/19
Printed Name and Title Date

DEPARTMENT USE ONLY

The above plan of correction is approved as of 7-24-19 (Date)

The above plan of correction was approved by AG (Initials)

Plan of correction implementation status as of 7-24-19 (Date)

- ☐ Fully Implemented
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- ☐ Partially Implemented - Inadequate Progress
- ☐ Not Implemented

Alternate Exit Routes

Regulations

2600.
132.f. Alternate exit routes shall be used during fire drills.

Description of Violation

Zone 2 was the only exit route used during the fire drills held from 7/2018-10/2018.
Zone 1 was the only exit route used during the fire drills held from 11/2018-2/2019.

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 occuring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

132f – Fire Drill evacuation areas will be alternated. Drill supervisor has been re-educated on regulation and the need to alternate locations of evacuation. Administrator will monitor for compliance.

Legal Entity Representative

Signature

Mary Heil PCHA 6/26/19
Printed Name and Title Date

DEPARTMENT USE ONLY – DO NOT WRITE IN THIS BOX

The above plan of correction is approved as of 6-27-19 (Date)

The above plan of correction was approved by AJ (Initials)

Plan of correction implementation status as of 6-27-19 (Date)

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- ☐ Not Implemented

227g - Support Plan Signatures

Regulations

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

Description of Violation

The Signature Page (Page 12), for Resident's # 1, 2, 3, 4 and 5 current Assessment and Support Plans (R.A.S.P.) did not include those staff who participated in the resident's support plans. It was determined through an interview, that this staff person would typically be the one who assessed the resident's needs and determined an appropriate plan then presented the plan to the resident for review.

*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.)

227g – Administrator and Care Service Manager have been educated on need for staff signing as a participant in reviewing the RASP with resident. Administrator will monitor for compliance.

Legal Entity Representative

[signature] — Signature

Marc Heil PCHA — Printed Name and Title

6/26/19 — Date

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