



**pennsylvania**

DEPARTMENT OF HUMAN SERVICES

Sent via emailed to: [REDACTED]

**MAILING DATE: June 18, 2015**

Mr. Mark Pyle, 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. Pyle:

As a result of the Department of Human Services' licensing inspection on April 8, 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.

Sincerely,

A handwritten signature in cursive script that reads "Anne Graziano".

Anne Graziano  
Regional Licensing Administrator

Enclosure  
Licensing Inspection Summary



Violation Report: 21496 - 04/08/2015 - Novak, Ryan  
 PCH 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 #1's nursing notes indicate a PRN ativan gel was administered at 8:00am and 9:45am on 3/26/15 the administration of the medication was not recorded on the MAR.

**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.*

*Please see attachment.*

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 - PCH Adm.*

Date

*05-30-15*

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

The above plan of correction is approved as of

6-10-15  
 (Date)

Plan of correction implementation status as of

6-10-15  
 (Date)

The above plan of correction was approved by

*OP*  
 (Initials)

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

2a. Description of Violation – Regulation 55 Pa. Code 2600.187

Resident #1's nursing notes indicate a PRN ativan gel was administered at 8:00 am and 9:45 am on 3/26/15 the administration of medication was not recorded on the MAR.

3. Plan of Correction

This regulation is important because it provides a record of proper medication administration and creates a system of accountability for controlled substance.

The medication was administered to a resident in crisis who was awaiting transportation to an acute facility. After several interventions were utilized to assist the resident with her anxiety her MD ordered two stat doses of PRN ativan gel to assist the resident who was having an increase in anxiety. The first dose was given with little effect and a second dose was ordered. Both medications were administered as ordered but were not documented in the MAR.

Staff was educated on the importance of documenting medication administration. This was done immediately with staff and also at the staff meetings held on April 21<sup>st</sup>, 23<sup>rd</sup> and 24<sup>th</sup> by the Unit Nurse Manager.

Going forward we will add this to our Quality Improvement Measurement. Random checks of the nurses' notes and comparing them to the MAR for completeness of medication administration documentation.

This will be done by the Nurse Manager and the Administrator. The schedule for the monitoring will be the following:

First Month: review one file a week X four weeks to start the week of May 25th

Second Month: review two files in a month

Third Month: review one file in a month

This will continue until there is no incident of missed documentation in the MAR

*Michelle P. Olivier*  
Michelle P. Olivier P.C.H.A.

05/30/15

Anne Gostaw, RLA, 6-10-15