pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via e-mail: michelea@lutheranhomekane.org
reginag@lutheranhomekane.org

MAILING DATE: February 5, 2020

Ms. Michele Avenali
Administrator
Lutheran Home at Kane Residential Care Center
100 High point Drive
Kane, Pennsylvania 16735

RE: Lutheran Home at Kane
License #: 426450

Dear Ms. Avenali:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on October 23, 2019, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Jody Garvey
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

RECEIVED
1/24/2020
Western Region Field Office
Bureau of Human Services Licensing

Violation Report

Facility Information

Name: *LUTHERAN HOME AT KANE/RESIDENTIAL CARE CENTER* **License Number:** *42645*
Address: *100 HIGH POINT DRIVE, KANE, PA 16735*
County: *MCKEAN* **Region:** *WESTERN*

Administrator

Name: *Michele Avenali* **Phone:** *8148378770* **Email:** *CFLORAVIT@LUTHERANHOMEKANE.ORG*

Legal Entity

Name: *LUTHERAN HOME AT KANE*
Address: *100 HIGH POINT DRIVE, KANE, PA, 16735*

Certificate(s) of Occupancy

Type: *I-2* **Date:** *11/10/2010* **Issued By:** *Commonwealth of PA*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *19* **Waking Staff:** *14*

Inspection

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

Inspection Dates and Department Representative

10/23/2019 - On-Site: Laurie Garrigan, Amy Duncan

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33* **Residents Served:** *19*

Secured Dementia Care Unit

In Home: *No* **Area:** **Capacity:** **Residents Served:**

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *3*
Are 60 Years of Age or Older: *17*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *0*
Have Physical Disability: *0*

132c - Fire Drill Records

Regulations

2600.

132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

The fire drill record for the fire drills conducted on the following dates did not include the time it took to evacuate in minutes and seconds:

* 12/28/18 at 2:09 p.m. - evacuation time was 4 minutes
* 3/26/19 at 1:16 p.m. - evacuation time was 2 minutes
* 5/28/19 at 8:08 p.m. - evacuation time was 6 minutes
* 7/22/19 at 6:29 p.m. - evacuation time was 2 minutes

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.)

A meeting was held 12/19/19 between the RCC Director, RCC Assistant Director, Maintenance Director and Maintenance Assistant Director. Discussion consisted of the review of all prior drills noting that the other 8 did include "minutes and seconds", the need to always record times in both minutes and seconds and that when an evacuation ends on an even minute that we will include "0 seconds" in documentation. Effective immediately all parties agree to document as such. Starting January 2020 following the fire drill the RCC Director or the Director Assistant will review the documentation to ensure the drill was completed properly. To ensure proper completion of fire drills a long term monitoring tool has been implemented. Each month following the unannounced fire drill The RCC Director or Assistant Director will complete a monitoring tool verifying that all residents present in the facility at the time of the drill were successfully evacuated, time was kept with the use of two stop watches if necessary and the drill has been documented in both minutes and seconds.
Meeting minutes, sign off as well as monitoring tool with instructions is attached

Legal Entity Representative

Michele Avenali LPN PCHA — Signature

Michele Avenali LPN PCHA — Printed Name and Title

12/20/19 & 1/24/2020 — Date

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The above plan of correction is approved as of 1/30/20 (Date)

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

Plan of correction implementation status as of 1/30/20 (Date)

☑ Fully Implemented

☐ Not Implemented

132d - Evacuation

Regulations

2600.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 4/23/19 at 12:55 p.m., the home conducted a fire drill and 2 residents did not evacuate, 17 of the 19 residents present in the home evacuated.

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.)

A meeting was held 12/19/19 between the RCC Director, RCC Assistant Director, Maintenance Director and Maintenance Assistant Director. Discussion consisted of the review of all prior drills and that when fire drills are held the time for evacuation must include every resident. Regulation 132 A – states 2 stop watches be used. If when checking the home, you discover that all residents have evacuated, the time recorded by the first stopwatch if the official fire drill time. If, on the other hand, you discover that one or more residents did not evacuate, the time recorded by the second stopwatch is the official fire drill time. In the latter case, it is recommended that both times be recorded on the fire drill log (132C) to demonstrate that most residents were able to evacuate in time, since the scope of the problem is related to developing an acceptable plan of correction. We will then educate residents on the importance of fire drills, and then hold another fire drill. Starting January 2020 following the fire drill the RCC Director or the Director Assistant will review the documentation to ensure the drill was completed properly. To ensure proper completion of fire drills a long term monitoring tool has been implemented. Each month following the unannounced fire drill The RCC Director or Assistant Director will complete a monitoring tool verifying that all residents present in the facility at the time of the drill were successfully evacuated, time was kept with the use of two stop watches if necessary and the drill has been documented in both minutes and seconds.

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Michele Avenali LPN PCHA — Michele Avenali LPN PCHA — 12/20/19 & 1/24/2020

Signature — Printed Name and Title — Date

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141a 1-10 Medical Evaluation Information

Regulations

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident #1's initial medical evaluation, dated 1/3/19, did not include an evaluation of the resident's body positioning/movement, health status or cognitive functioning. These sections of the form were blank.

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.)

Corrected 10/24/19 by nurse following inspection. Staff was educated and signed off understanding 12/20/19 in an effort of preventing reoccurrence. Effective immediately 12/20/19, the RCC Director and/or RCC Assistant Director will review all DME forms upon their return from the doctor. The review is to ensure that all sections of the form are filled out in their entirety, signed and dated. In the event of blanks, the form will be returned to the physician to be completed by either the physician or nurse if applicable.. If entire form is completed properly, date and initial in the bottom left corner to show that it has been reviewed and is complete. This process was initiated on 10/31/19 with a DME completed 10/30/19. All sections were complete. See attached.

On 1/22/2020 an additional longterm monitoring tool was initiated to document the double check of completion of DME and RASP review, to insure that no blanks were left and that the documents have been completed in their entirety and have been initialed and dated by staff. This is to be completed by Director and/or Assistant Director upon completion of DMEs and RASPs

Legal Entity Representative

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185a - Implement Storage Procedures

Regulations

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.

Description of Violation

Resident #1 was prescribed Triamcinolone 0.1 % ointment-apply topically to right nose twice daily as needed. On 10/23/19 at 1:53 p.m., the medication was not available in the home.

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 had a skin irritation which required the routine administration of the above mentioned ointment. Upon healing, staff sought an order to maintain the ointment on a prn basis as this skin condition had been intermittent and a repetitive occurrence. During a quarterly QA the ointment was found to be expired, was disposed of, was not immediately reordered as it had not been used in more than 6 months but a discontinuation order was also not sought and the order continued to be carried on the MAR. A D/C order has been sent to the PCP and an educational memo was put out to all staff.

See Attached for d/c order, initial educational memo/ sign off and longterm followup and monitoring education/prodedure

Staff was educated and informed on 12/20/19 and again at staff meeting on 1/22/2020 in regards to medication QA. All staff is aware that beginning 1/22/2020 we will impliment our first monthly QA as part of our Plan of Correction. This will occur monthly for 3 months (January 2020, February 2020, March 2020) and then return to quarterly. The QA procedure specifies to check that all medications listed on the QMAR are present in the facility and are within the expiration date, initial and date beside every medication that you have checked that it is here and okay and what to do if you find that a listed medication is not present or is expired. All staff are responsible for the completion of the QA and when complete will be turned in to the Administrator or Assistant Director

Legal Entity Representative

Michele Avenali LPN PCHA

Signature

Michele Avenali LPN PCHA **12/20/19 & 1/24/2020**

Printed Name and Title Date

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227d - Support Plan Medical/Dental

Regulations

2600.

227.d. Each home shall document in the resident's support plan the medical, dental, vision, hearing, mental health or other behavioral care services that will be made available to the resident, or referrals for the resident to outside services if the resident's physician, physician's assistant or certified registered nurse practitioner, determine the necessity of these services. This requirement does not require a home to pay for the cost of these medical and behavioral care services.

Description of Violation

The assessment for resident #2, dated 4/11/19, indicates the resident has a need for total physical assistance managing finances. The resident's support plan, dated 4/26/19, does not document how this need will be met.

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.)

Corrected 10/25/19 by nurse following inspection. In an effort of preventing reoccurrence, effective immediately, the RCC Director, RCC Assistant Director and/or another assigned staff member will review all completed RASPs to assure they have been completed in their entirety and no blank fields have been left. On 12/20/19 staff was educated and signed off understanding that following the completion of RASP, another staff member is to check that it is filled out entirely. If there are any blanks, bring it to the attention of the person that had completed it, the RCC Director or RCC Assistant Director and we will discuss how to proceed. If entire form is completed properly, date and initial in the bottom left corner of signature page to show that it has been reviewed and is complete.

On 1/22/2020 an additional longterm monitoring tool was initiated to document the double check of completion of DME and RASP review, to insure that no blanks were left and that the documents have been completed in their entirety and have been initialed and dated by staff. This is to be completed by Director and/or Assistant Director upon completion of DMEs and RASPs

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251b - Record Entries Legible

Regulations

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on the signature line of resident #3's contract addendum dated 1/11/19.

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.)

Staff has been educated on the proper way to note errors and that correction fluid is to never be used on any portion of a resident's permenant record whether it be resident's documentation, medical, financial, in the nurse notes or support plans..
REGULATION 251b states – The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

On 12/18/19 staff education was completed and signed for understanding. 1/22/2020 an additional monitoring tool was initiated in which for the next 3 months starting with January 2020 the Director or Director Assistant will review new admission paperwork, RASPs and nurse notes to assure errors are being corrected properly, that no correction fluid was used on a permanent document and log the findings. Begining April 2020 this will be added to the quarterly Q.A.'s

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