pennsylvania
DEPARTMENT OF HUMAN SERVICES

SENT VIA EMAIL: mweichey@concordialm.org

MAILING DATE: June 16, 2020

Ms. Melissa Weichey
Administrator
Concordia Lutheran Ministries of Pittsburgh
1300 Bower Hill Road
Pittsburgh, Pennsylvania 15243

RE: Concordia of Franklin Park
1600 Georgetown Drive
Sewickley, Pennsylvania 15143
Certificate #: 443630

Dear Ms. Weichey:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on November 13, 2019; November 14, 2019; May 6, 2020; May 7, 2020; May 11, 2020; May 13, 2020 and May 14, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

Larry Mazza
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *CONCORDIA OF FRANKLIN PARK* License Number: *44363*
Address: *1600 GEORGETOWN DRIVE,, SEWICKLEY, PA 15143*
County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: *Melissa Weichey* Phone: *7249351075* Email: *mweichey@CONCORDIALM.ORG*

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*
Address: *1300 BOWER HILL ROAD, PITTSBURGH, PA, 15243*

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *06/04/1999* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *89* Waking Staff: *67*

Inspection

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

Inspection Dates and Department Representative

11/13/2019 - On-Site: Ashley Roser, Trish Bartlett, Courtney Barry

11/14/2019 - On-Site: Ashley Roser, Trish Bartlett, Courtney Barry

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* Residents Served: *71*

Secured Dementia Care Unit

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

Hospice

Current Residents: *9*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *71*
Diagnosed with Mental Illness: *0*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *18*
Have Physical Disability: *6*

18 - Compliance With Laws

Regulations

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. No carbon monoxide detectors are present in close proximity to the 2 gas dryers in the back of the home's laundry room in accordance with the Care Facility Carbon Monoxide Alarms Standards Act.

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.)

Carbon monoxide detector was replaced immediately. Maintenance will check placement of all carbon monoxide detectors weekly for 4 weeks and then monthly.

Attachment #1

Legal Entity Representative

Signature

Melissa Weichey - Administrator — Printed Name and Title

2/6/2020 — Date

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

The above plan of correction is approved as of 2/10/2020 (Date)

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

Plan of correction implementation status as of 5/15/2020 (Date)

☒ Implemented
☐ 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

On 11/11/19 and 11/12/19, there were 71 residents in the home, including 18 residents with mobility needs. Of the 18 residents with mobility needs, 9 residents require the assistance of 2 staff persons to transfer in/out bed/chair, including 5 residents who require transfer assistance with the use of a Hoyer lift and 2 residents who require transfer assistance with the use of a Sara Lift. Also, 5 of the residents with mobility needs require the assistance of 1 staff person to transfer in/out of bed/chair with the use of a sit-to-stand lift.

The home's most recent fire safety inspection conducted by a fire safety expert, dated 5/2/19, indicates the maximum safe-evacuation time to the numerous fire-safe areas is 12 minutes. However, only 3 staff members were on duty on 11/11/19 and 11/12/19 from 10:00 PM to 6:00 AM, which is not adequate to safely evacuate all residents in the event of an emergency.

Plan of Correction (POC)

(Attach pa prevent a

Concordia Visiting Nurses Physical and Occupational therapists will complete mobility screenings on all residents currently deemed immobile by 2/14/2020. The house physician or CRNP will review the therapists recommendations and write orders accordingly. Any residents with change to their mobility/transfer status will have a RASP update within 5 days of the change.

Administrator, Resident Care coordinator and Maintenance director will work together to complete monthly review of fire/emergency procedures on the night shift monthly x 6 months to ensure staff awareness and comfort level with meeting the needs of the residents during emergency situations.

Night time fire drills will be conducted 4 times in 2020.

The building is fully sprinklered and has multiple fire safe areas.

Actively hiring midnight shift nursing assistants with goal of having 4 staff members on the midnight shift. Currently have 1 full time and 2 part time nursing assistants completing the hiring process for the night shift. Immediately: A designated staff person shall review the staff schedule daily to ensure staffing is provided to meet the needs of the residents in accordance with resident assessments and support plans.

Legal Entity Representative

2/10/2020 LM

Signature

Melissa Weichey - Administrator — Printed Name and Title

2/10/2020 — Date

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☒ Implemented BB

☐ Not Implemented

81b - Resident Personal Equipment

Regulations

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

On 11/13/19, the bed enablers attached to residents #5 and #6's beds were loose, and not securely attached attached to their beds.

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.)

Enablers were tightened immediately. All other enablers were also checked immediately. Staff teaching to be completed by 1/29/2020; For safety purposes All enablers (bed canes, halos) must be tightly secured to the bed and covered at all times. Any loose or seemingly ill fitting enablers will be reported to maintenance immediately. All enablers must be covered at all times. If staff person finds an uncovered enabler- cover it. If I specifically designed cover is unavailable use a pillow case. Additionally, Maintenance will complete monthly checks of all enablers to ensure they are secure and covered.

Attachment #2

Legal Entity Representative

Signature

Melissa Weichey - Administrator — Printed Name and Title

2/6/2020 — Date

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☒ Implemented
☐ Not Implemented

88a - Surfaces

Regulations

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 11/13/19, dirt and grime covered the entire tile floor in the shared bathroom of residents #1 and #2.

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.)

Grout on tile floor was deep cleaned day #1 of inspection. Resident and state inspector re-evaluated and were pleased with the cleanliness and appearance of the tile floor. Bathrooms are cleaned up 5-7 days per week and each bathroom floor is mopped weekly and as needed. Administrator or designee will conduct room rounds weekly to validate cleanliness.

Attachment #3

Legal Entity Representative

Melissa Weichey — Signature

Melissa Weichey - Administrator — Printed Name and Title

2/6/2020 — Date

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95 - Furniture and Equipment

Regulations

2600.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

On 11/13/19, resident #1's towel hook was broken in the resident's shared bathroom.

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.)

Towel hook was replaced day of inspection. Staff education to be completed by 1/29/2020 Re: items required and items prohibited from resident rooms. Audit form regarding room rounds initiated and started 2/3/20. Administrator or designee will audit at least 10% of rooms weekly for compliance.

Attachment #3 Teaching – room rounds and #11

Legal Entity Representative

Melissa Weichey — Signature

Melissa Weichey - Administrator — Printed Name and Title

2/6/2020 — Date

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102i - Soap Dispenser

Regulations

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 11/13/19 at 10:15 AM, there were 2 white bars of soap in a soap dish in the common resident bathroom next to bedroom 106P.

On 11/13/19 at 11: 15 AM, there was a purple container which contained an unlabeled bar of soap in the shared bathroom of residents #3 and #7.

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.)

Unlabeled bar soaps were thrown away immediately. Facility will provide bottled soap and body washes unless a resident is ordered a specific bar soap. Facility will provide a labeled soap dish for any resident residing in a shared room that has a need or desire to use a bar soap. Audit form regarding room rounds initiated and started 2/3/20. Administrator or designee will audit at least 10% of rooms weekly for compliance.

Attachment #3 Teaching – room rounds and #11

Legal Entity Representative

Signature | Melissa Weichey – Administrator (Printed Name and Title) | 2/6/2020 (Date)

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127a - Portable Space Heaters

Regulations

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

On 11/13/19 at 4:01 PM, a white comfort zone portable space heater was present and in-use in resident #9's bedroom.

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.)

Space heater was removed immediately. Discussion occurred with resident and dtr that portable space heaters are prohibited. Staff also educated that portable space heaters are prohibited and to remove any portable space heaters immediately. Notify shift supervisor who will notify resident, family and administrator. Audit form regarding room rounds initiated and started 2/3/20. Administrator or designee will audit at least 10% of rooms weekly for compliance.

Attachment #3 Teaching- room rounds and #11

Legal Entity Representative

Melissa Weichey
Signature

Melissa Weichey - Administrator 2/6/2020
Printed Name and Title Date

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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 drill conducted in April 2019 indicates the fire drill was conducted on 4/28/19; however, the monitoring records from the alarm company indicates the fire drill was conducted on 4/29/19.

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.)

The fire drill was completed properly and timely per regulations. An entry error occurred on the fire drill record due to the fact that the drill was completed at 12:30 am. The staff member conducting the drill entered the date as 4/28/19 when the date changed 30 min prior at midnight. Administrator to conduct clerical audit of fire drills on monthly basis. **{Clerical Error}**

Legal Entity Representative

Signature | Melissa Weichey Administrator (Printed Name and Title) | 2/6/2020 (Date)

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132h - Designated Meeting Place

Regulations

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

According to multiple staff interviews, the residents that reside in the memory care unit of the home, as well as residents in the 2nd floor north and 2nd floor west wings, do not evacuate to the designated meeting place outside of the home or the designated fire-safe areas during fire drills.

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.)

Franklin Park Boro fire safety expert re-visited the facility on 11/22/2019 to clarify the fire safe areas. Residents are and always have been evacuated to proper fire safe areas. Facility drawings have been updated and reviewed with dept managers and staff. Review continues after each fire drill. Monthly audit of fire drills to be completed by maintenance and administrator to ensure all residents are evacuated properly.

Attachment #4, #5, #6, #13 Revised letter and fire safe area diagrams of first and second floor resident housing

Legal Entity Representative

Melissa Weichey
Signature

Melissa Weichey - Administrator
Printed Name and Title

2/6/2020
Date

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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 #6's glucometer is not calibrated to the correct date and time.

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.)

Immediately: Resident #6's glucometer shall be calibrated to the current date and time. 2/10/2020 FM

Glucometer teaching to be completed with nurses and med techs by 1/29/2020

Attachment #7

Resident care coordinator will complete weekly glucometer audits for 4 weeks then monthly.

Attachment #8

Legal Entity Representative

Signature

Melissa Weichey - Administrator
Printed Name and Title

2/6/2020
Date

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187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

Resident #8 is prescribed Novolog Flex pen 100u/ml-Inject 8 units subcutaneously before meals; however, the resident's November 2019 medication administration record (MAR) indicates that the resident was given 137 units of insulin.

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 was administered 8 units of insulin as ordered. The nurse made an entry error when she entered the glucometer reading in the physical monitor for number of units given on the MAR. The glucometer reading for that day was 137- entered in another location on the MAR.

Standing insulin orders will no longer have physical monitors for number of units administered attached to the order which will reduce the chance of entry errors. Re-education will be completed with all nurses and med techs by 2/7/2020. Resident care coordinator will complete weekly glucometer audits. The audits shall include a review of resident MAR's to ensure accurate documentation. 2/10/2020 FM

Attachment #8 (audit form) and Attachment #10 (teaching) + sign in sheet

Legal Entity Representative

Melissa Weichey Melissa Weichey - Administrator 2/10/2020
Signature Printed Name and Title Date

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☐ Not Implemented

187b - Date/Time of Medication Admin.

Regulations

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #6 is prescribed Eliquis 5 mg-Take 1 tablet orally 2 times daily. On 11/1/19 at 4:00 PM, a staff member documented on the resident's November 2019 MAR that the medication was not administered, because it was outside the order parameters; however, the medication was administered to the resident.

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.)

Eliquis was given as ordered. Med tech who administered medication was re-trained on 1/23/2020 on examples of when to use "outside order parameter" and documenting in notes to clarify any unusual documentation. Re-education will be completed with all nurses and med tech by 2/7/20. RCC will complete weekly audits for any documented "outside order parameter" investigate reason and ensure proper documentation.

Attachment #9-teaching form

Legal Entity Representative

Melissa Weichey — Administrator — 2/6/2020

Signature | Printed Name and Title | Date

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☐ Not Implemented

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #8 is prescribed Novolog 100u/ml Flex pen 100u/ml-Inject subcutaneously 4 times daily in accordance with the following sliding scale: <70 call MD; 0-150=0 units; 151-200=2 units; 201-250=3 units; 251-300=4 units; 301-350=5 units; 351-450=6 units; Greater than 450=call doctor.

However, on 11/11/19 at 8:00 AM; the residents blood sugar was 116, which did not require insulin administration in accordance with the sliding scale; however, 8 units of insulin was administered.

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 was given daily standard order 8 units Novolog flexpen as ordered, an entry error occurred when the physical monitors of site, units given auto filled on the sliding scale order for the Novolog flexpen. The medication was not given twice. The nurse was re-educated on documentation of medication and physical monitors attached to orders. To further prevent this type of entry order, straight insulin orders will not have a physical monitor of units attached. Removal of physical monitor – units- for straight insulin orders will be complete by 2/7/20. Training on physical monitors for insulin orders to be completed with nurses and med techs by 2/7/20. Resident care coordinator or designee will complete weekly glucometer audits for 4 weeks then monthly. The audits shall include a review of resident MAR's to ensure accurate documentation. 2/10/2020 LM

Attachment #8-audit and #10-teaching

Legal Entity Representative

Melissa Weichey
Signature

Melissa Weichey - Administrator 2/6/2020
Printed Name and Title Date

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☒ Implemented
☐ Not Implemented

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

Resident #4's most recent assessment and support plan, dated 9/11/19, indicates in the assessment that the resident is a 2-person assist with a Sara Lift for all transfers; however, the resident's support plan for mobility indicates that the resident is a 1-person assist with a Sara Lift and does not indicate the resident's need for a 2-person assist with a Sara Lift.

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.)

RASP update was completed day of inspection; Resident uses the Sara lift and Assist X2 for transfers. All RASP's will be audited by 3/6/20 to ensure proper care and mobility needs. Resident Care Coordinator will complete monthly chart audits of at least 10% charts of existing residents and all new admissions.

Attachment #12-audit form

Legal Entity Representative

Melissa Weichey

Signature

Melissa Weichey - Administrator

Printed Name and Title

2/6/2020

Date

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☒ Implemented

☐ 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

Resident #3's most recent support plan, dated 9/4/19, is not signed by the resident, and does it indicate the resident was unable to participate, declined to participate, refused to sign or was unable to sign.

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 is and has been unable to participate in their support plan. Resident RASP was updated to reflect the resident's inability to sign RASP form. Administrator and RCC have reviewed the RASP. Phone call will be made to the family offering a face to face care conference and/or a phone review of the support plan.

Resident care coordinator and Administrator will review and sign off on any RASP that the resident refuses or is unable to participate in. RCC or designee will conduct audit of least 10% of RASP's monthly to ensure compliance.

Attachment #12-audit form

Legal Entity Representative

Melissa Weichey — Signature

Melissa Weichey – Administrator — Printed Name and Title

2/10/2020 — Date

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