



SENT VIA EMAIL: david.gritzer@lutheranseniorlife.org
samantha.rapuk@lutheranseniorlife.org

MAILING DATE: June 2, 2020

Mr. David Gritzer
Executive Director
St. John Lutheran Care Center
500 Wittenberg Way, PO Box 928
Mars, Pennsylvania 16046

RE: St John Specialty Care Center
Certificate #: 448330

Dear Mr. Gritzer:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) review on February 11, 2020, of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

A handwritten signature in black ink that reads "Jody Garvey". The signature is written in a cursive style.

Jody Garvey
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary

Violation Report

Facility Information

Name: *ST. JOHN SPECIALTY CARE CENTER* License Number: *44833*
 Address: *500 WITTENBERG WAY, P.O.BOX 928, MARS, PA 16046*
 County: *BUTLER* Region: *WESTERN*

Administrator

Name: *Samantha Rapuk* Phone: *7246251571* Email: *SAMANTHA.RAPUK@LUTHERANSENIORLIFE.ORG*

Legal Entity

Name: *ST JOHN LUTHERAN CARE CENTER*
 Address: *500 WITTENBERG WAY, P.O. BOX 928, MARS, PA, 16046*

Certificate(s) of Occupancy

Type: *C-1* Date: *06/01/1965* Issued By: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *20* Waking Staff: *15*

Inspection

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

Inspection Dates and Department Representative

02/11/2020 - On-Site: Desmond Grace, Lori Gillette, Thomas Smith

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *36* Residents Served: *15*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *15*
 Diagnosed with Mental Illness: *7* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *5* Have Physical Disability: *0*

3c - Post Current License

Regulations

2600.

3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At 10:15 a.m., the home's licensing inspection summaries dated 9/30/19 and 12/5/19, were not posted in a conspicuous and public place in the home.

Repeat Violation: 2/27/19

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.)

As of 2/11/2020, a copy of the license inspection summaries dated 9/30/2019 and 12/5/2019 were posted on a bulletin board in front of the nurses' station. These postings were observed by the surveyors on 2/11/2020. Beginning 5/1/2020 and ongoing, a copy of all inspection reports will be posted by the administrator as they are received and will be initialed by the Administrator and the LPN. Beginning 5/1/2020 and ongoing, an audit will be done monthly to ensure that all postings are in place and up-to-date. Documentation of audits shall be kept and reviewed in facility QAPI meetings. See attached audit.

Legal Entity Representative



Signature

SAMANTHA RAPAK, PCHA 5/7/2020
Printed Name and Title Date

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The above plan of correction is approved as of 5/14/20
(Date)

Plan of correction implementation status as of 5/14/20
(Date)

The above plan of correction was approved by 
(Initials)

Implemented
 Not Implemented

65f - Training Topics

Regulations

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 1. Medication self-administration training.
- 6. Safe management techniques.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Staff person A, hired 9/26/16, did not complete training in medication self-administration, safe management techniques and care for residents with mental illness or intellectual disability during the 1/1/19-12/31/19 annual staff training year.

Repeat Violation: 2/27/19

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 Person A has not worked in Personal Care since prior to the survey. Staff person A is on a reduced schedule and will not be in the facility again until 5/16/2020. Staff person A will complete training in Medication Self Administration, Safe Management Techniques, and Care for Residents with Mental Illness by 5/16/2020. Staff person A will not be permitted to work in Personal Care until this training is complete.

A plan for tracking these educational pieces was put in place by 4/15/2020. To ensure that all direct care staff receive annual training in the areas of medication self-administration training, safe management techniques, and care for residents with mental illness or an intellectual disability or both, the staff will receive training upon hire during their floor orientation, ongoing orientation as needed, have opportunities to review modules on RELIAS with exams at the end to test their knowledge, have opportunities to attend live informational sessions throughout the year, and will have the opportunity to attend the Medication Technician (med tech) training classed offered on-site throughout the year. See attached training plan

All staff involved in tracking this information were educated on 4/23/2020. See attached documentation. Beginning 4/23/2020 and ongoing, a spreadsheet will be maintained with all learning opportunities available and required listed and the persons who attended that training also listed. Monthly RELIAS reports will be run, showing which employees have completed the assigned modules. Also, a record will be kept as to who attended new hire and yearly orientation with associated topics covered during those sessions. These audits will be reviewed in facility QAPI meetings. See attached audit.

Legal Entity Representative



Signature

Samantha Rapke PCAA 5/7/2020
Printed Name and Title Date

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65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 3. Resident rights.

Description of Violation

Staff person A, hired 9/26/16, and staff person B, hired 12/4/18, did not complete training in resident rights during the 1/1/19 -12/31/19 annual staff training year.

Repeat Violation: 2/27/19

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 person B completed training in Resident Rights on 5/4/2020. See attached documentation.

Staff Person A has not worked in Personal Care since prior to the survey. Staff person A is on a reduced schedule and will not be in the facility again until 5/16/2020. Staff person A will complete training in Resident Rights by 5/16/2020. Staff person A will not be permitted to work in Personal Care until this training is complete.

A plan for tracking these educational pieces was put in place by 4/15/2020. To ensure that all staff receive annual training in the area of resident rights, the staff will receive training upon hire at orientation, at annual orientation, have opportunities to review modules on RELIAS with exams at the end to test their knowledge, and have opportunities to attend live informational sessions throughout the year.

All staff involved in tracking this information were educated on 4/23/2020. See attached documentation.

Beginning 4/23/2020 and ongoing, a spreadsheet will be maintained with all learning opportunities available and required listed and the persons who attended that training also listed. Monthly RELIAS reports will be run, showing which employees have completed the assigned modules. Also, a record will be kept as to whom attended new hire and yearly orientation with associated topics covered during those sessions. These audits will be reviewed in facility QAPI meetings. See attached audit.

Legal Entity Representative

Samantha Rapic
Signature

SAMANTHA RAPIC PCHA 5/7/2020
Printed Name and Title Date

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- Implemented
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85d - Trash Receptacles

Regulations

2600.

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 10:30 a.m., there were two large uncovered trash cans in the kitchen of the home that were 1/4- 1/2 filled with trash.

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.)

On 2/11/2020, lids were put on the trash cans in the kitchen.

On 2/18/2020 and 3/18/2020, staff were educated on this requirement. Going forward, all new hires will be educated on this requirement. Director of Dining Services and the managing team will continue to give education on Proper Sanitation Protocols. See attached documentation.

Beginning 2/18/2020 and ongoing, a line has been added to the Opening/Closing checklist that the managers complete that ensures that they are checking that all trash cans have lids. The Director of Dining Services is also working with purchasing trash can lids with "push through flaps" that would allow the trash cans to be covered and eliminates the need for the staff to remove the lids entirely. These audits will be reviewed in facility QAPI meetings. See attached document.

Legal Entity Representative


Signature

SAMANTHA RAPUC PHA
Printed Name and Title

5/7/2020
Date

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92 - Windows

Regulations

2600.

92. Windows and Screens - Windows, including windows in doors, must be in good repair and securely screened when doors or windows are open.

Description of Violation

Resident bedrooms #304, #313, and #320 had windows that opened to the exterior of the home; however, the windows did not have screens in them.

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.)

On 4/20/2020, window screens were installed in rooms #304, #313, and #320 by the maintenance department. See attached work order.

Beginning 5/1/2020 and ongoing, all staff have been and will continue to be educated on this requirement. Staff will be re-educated on submitting a work order and notifying the administrator when missing or ripped screens are identified. See attached education.

Beginning 5/1/2020 and ongoing, window screen presence and quality inspections shall become an ongoing responsibility of the facilities Environmental Rounds team with inspection occurring at least one time per month during their rounds. Work orders will be generated to the Facilities Department by the Environmental Rounds team or other stakeholders for corrections of missing or damaged window screens. These audits will be reviewed in facility QAPI meetings. See attached document.

Legal Entity Representative



Signature

SAMANTHA RARUK PCMA 5/7/2020
Printed Name and Title Date

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93a - Handrails

Regulations

2600.

93.a. Each ramp, interior stairway and outside steps must have a well-secured handrail.

Description of Violation

There was an approximately 6-8 inch step outside of the 2nd floor emergency exit into the habitat area that did not include a handrail or railing.

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 handrail was placed at the exit into the Habitat on 4/28/2020. See attached work order. Beginning and ongoing, 5/15/2020, handrails throughout the facility will be inspected monthly by the safety committee as part of each Safety Committee members assigned Safety Walkthrough. Requested repair of any handrail deficiencies made by the Safety Committee or other stakeholder, will be entered in the Facilities work order system and addressed by the maintenance department as an emergent Safety repair. These audits will be reviewed in facility QAPI meetings. See attached form.

Legal Entity Representative

Samantha Raruk
Signature

SAMANTHA RARUK PCHA 5/7/2020
Printed Name and Title Date

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123c - Evacuation Diagrams

Regulations

2600.

123.c. For a home serving nine or more residents, an emergency evacuation diagram of each floor showing corridors, line of travel to exit doors and location of the fire extinguishers and pull signals shall be posted in a conspicuous and public place on each floor.

Description of Violation

On 2/11/20, 15 residents resided in the home; however the emergency diagram located in the main hallway of the home did not include all corridors, lines of travel to the exit doors, locations of fire extinguishers, and/ or pull stations 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.)

Beginning 5/18/2020, the Facilities Maintenance Director and the Preventative Maintenance Coordinator (technical support) will develop and post emergency evacuation diagrams in the unit. The diagrams will clearly illustrate corridors, exit doors, lines of travel, fire alarm pull stations and fire extinguishers. Beginning 5/18/2020 and ongoing, the administrator will ensure that the emergency evacuation routes will be inspected monthly to ensure compliance with this regulation. These audits will be reviewed in facility QAPI meetings. See attached audit.

Legal Entity Representative



Signature

SAMANTHA RAPUC, PCHIA 5/7/2020
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130g - Smoke Detector Repair

Regulations

2600.

130.g. If a smoke detector or fire alarm becomes inoperative, repair shall be completed within 48 hours of the time the detector or alarm was found to be inoperative.

Description of Violation

The home's policy for inoperable smoke detectors did not indicate that repair will be completed within 48 hours of the time the detector or alarm was found to be inoperative.

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.)

As of 4/22/2020, the inoperable smoke detector policy has been updated to reflect that the repair of defective detection and alarm components will be completed within 48 hours of the time that the component was discovered to be deficient. See attached policy.

As of 5/7/2020, Maintenance and Personal Care Staff have been trained on this policy.

Beginning 9/1/2020 and ongoing, all policies will be reviewed for compliance annually and as needed. Updated policies will be reviewed in QAPI meetings, as needed.

Legal Entity Representative

Samantha Rapp
Signature

SAMANTHA RAPP PCA 5/7/2020
Printed Name and Title Date

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132a - Monthly Fire Drill

Regulations

2600.

132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the month of July 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 occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Beginning 2/11/2020, Fire Drills will be scheduled and performed monthly. The Maintenance Supervisor shall be responsible for the schedule development and the drill executions. Secondary drill schedule oversight is assigned to the Work Control Coordinator to perform as a backstop to the fire drill schedule being properly executed. These assignments are effective immediately. The schedule shall reside in the Maintenance Work Order system and also on a shared Maintenance Department MS Outlook calendar. See attached schedule. Beginning 3/1/2020 and ongoing, all drills results will be provided to the Personal Care Administrator, PC Unit Director, Safety Committee and the Facilities Director for full review and comment. These audits will be reviewed in facility QAPI meetings.

Legal Entity Representative

Samantha Rapu
Signature

SAMANTHA RAPU PCHA 5/7/2020
Printed Name and Title Date

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(Date)

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- Not Implemented

132b - Safety Inspection/Fire Drill

Regulations

2600.

132.b. A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

Description of Violation

The home's current fire safety inspection and fire drill completed by a fire safety expert was completed on 10/11/19. However, the previous fire safety inspection and fire drill was completed on 9/25/18.

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.)

While late, the facility has a fire safety inspection report completed for the facility. By 9/1/2020, a fire safety inspection and fire drill conducted by a fire safety expert will be conducted no later than 11 months after the previous fire safety inspection to ensure that it is done within the 12-month time frame. By 8/1/2020, the administrator will meet with the Director of Facilities to ensure that the fire safety inspection and drill are scheduled prior to 9/1/2020. This requirement will be reviewed in facility QAPI meetings, as well.

Legal Entity Representative



Signature

SAMANTHA RAPUC PCNA 5/7/2020
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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

On multiple dates to include 1/19/19, 2/28/19, 4/19/19, and 5/31/19, the home's written fire drill record did not include the exit routes used or number of residents evacuated.

Repeat Violation: 2/27/19

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.)

Effective 2/11/2020 the fire drill form that the facility will use has been changed to the DHS Fire Drill form that was downloaded from the DHS website. This form provides and demands that exit routes and the number of residents evacuated are recorded. See attached fire drill record.

By 5/1/2020, all maintenance staff will be educated on this form and the required information for recording fire drills by DHS.

Beginning 5/1/2020 and ongoing, the administrator will review the fire drill form for completion and accuracy of information. This will be reviewed in facility QAPI meetings.

Legal Entity Representative

Samantha Rapak
Signature

SAMANTHA RAPAK PCHA
Printed Name and Title

5/7/2020
Date

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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

During the fire drill on 9/15/19 at 8:13 p.m., the home exceeded the maximum safe evacuation time of 5 minutes, 33 seconds, as specified in writing by a fire safety expert on 9/25/18. The evacuation time was 6 minutes, 18 seconds.

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.)

Effective 2/11/2020 the drill time stipulated to evacuate the residents and staff to a fire safe area will be strictly monitored and adhered to.

Effective 2/11/2020, the Maintenance Department shall be charged with timing the drills to determine compliance to the designated maximum evacuation time as set by the fire expert. All time exceptions will be noted on the fire drill form and immediately reported to the shift nursing manager who is conducting the drill. Any drill that does not meet the time compliance standard as designated by the Fire Expert will be repeated after the PC staff re-educates the residents and prior to the month expiring. Fire drills shall be repeated until a time compliant result is achieved. The Unit Manager and the Maintenance supervisor shall be responsible, in collaboration, for a successful outcome of each monthly drill. See attached education.

Beginning 5/1/2020 and ongoing, monthly Fire Alarm reports shall be distributed to the Personal Care Administrator, PC Unit Director, Safety Committee and the Facilities Director for full review and comment. These reports will be reviewed in facility QAPI meetings. See attached documentation.

Legal Entity Representative


Signature


SAMANTHA RIPPE PCHA
Printed Name and Title

5/17/2020
^{see}
~~5/14/2020~~
Date

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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 #2 participated in the development of hcr support plan on 9/19/19. However, the resident did not sign the support plan.

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.)

As of 2/11/2020, Resident #2's support plan has been checked "Resident Unable to Sign." See attached Support Plan.

By 4/21/2020, a plan was developed with the Administrator and the LPN to ensure that all residents sign their RASPs or, if unable to sign, the correct boxes are checked on the RASP. Training for this was conducted on 4/21/2020. See attached education.

Beginning 4/21/2020 and ongoing, an audit of all resident RASPs was done to ensure that all residents who participated in their support plan signed and dated the support plan. If the resident was unable to sign, the appropriate box was checked. These audits will continue for 12 months. These audits will be reviewed in facility QAPI meetings. See attached audit.

Legal Entity Representative



Signature

SAMANTHA RAPIC PCHA 5/7/2020
Printed Name and Title Date

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