Department of Human Services
Bureau of Human Service Licensing

January 20, 2022

[redacted]

RE: LUTHERAN HOME AT
KANE/RESIDENTIAL CARE CENTER
100 HIGH POINT DRIVE
KANE, PA, 16735
LICENSE/COC#: 42645

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/05/2021, 08/06/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

[redacted]

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *LUTHERAN HOME AT KANE/RESIDENTIAL CARE CENTER*

License #: *42645*

License Expiration: *11/10/2021*

Address: *100 HIGH POINT DRIVE, KANE, PA 16735*

County: *MCKEAN*

Region: *WESTERN*

Administrator

[redacted]

Legal Entity

[redacted]

Certificate(s) of Occupancy

Type: *C-1*

Date: *05/23/1980*

Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0*

Total Daily Staff: *22*

Waking Staff: *17*

Inspection Information

Type: *Full*

Notice: *Unannounced*

BHA Docket #:

Reason: *Renewal*

Exit Conference Date: *08/06/2021*

Inspection Dates and Department Representative

08/05/2021 - On-Site: [redacted]

08/06/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33*

Residents Served: *22*

Secured Dementia Care Unit

In Home: *No*

Area:

Capacity:

Residents Served:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *5*

Are 60 Years of Age or Older: *22*

Diagnosed with Mental Illness: *1*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *0*

Have Physical Disability: *0*

Inspection Dates and Department Representative *(continued)*

Inspections / Reviews

08/05/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/26/2021*

01/03/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *01/10/2022*

01/18/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *01/25/2022*

01/20/2022 - Document Submission

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

88a - Surfaces

1. Requirements

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 8/5/21, approximately 6 inches of the cove base next to the fire exit door in the dining area was detached from the wall and there was water damage to the wall behind and around it.

Plan of Correction ***Accept***

Maintenance immediately came over the day of inspection. They checked the hinges, shimmed/made adjustments and filed away as much rust as possible to ease in the operation of the door. September 23 it was reported to me that maintenance has been in contact with a local company. The company is expected to come next week to inspect and measure the door and frame. We will have a new door and frame ordered to those specifications and installed upon it's arrival. A quote was received 10/21/2021 and order placed with the expected delivery date of "a couple weeks". A temporary repair of the wall is in progress. Upon the tearing out and instillation of the new door and frame, maintenance will be able to further assess and complete the final repairs to the surrounding wall at the base. Those dates are unknown as it is dependent on the ordering, arrival and replacement of the door and frame. Direct care staff has been educated as to upon manually locking and unlocking the exit doors daily to be mindful of the ease in operation and immediately fill out a maintenance slip to report any difficulties. The updated shipping information of the door is now 2/10/2022, maintenance director is scheduled to call on 2/11/22 to receive an "install date" from the company. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

103g - Storing Food

1. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

On 8/5/21, there were two trays containing 15 uncovered pie tarts on racks in the walk in cooler.

On 8/5/21, there was an unsealed plastic bag containing approximately 12 pinwheel pastries in the walk in freezer.

On 8/5/21, there was an uncovered and unlabeled/undated bowl of chocolate ice cream in the freezer section of the white refrigerator/freezer in the kitchenette.

Plan of Correction ***Accept***

All staff reeducated that food must be covered or in a sealed container and all food has to have a date on it as well as that if food belongs to a specific resident, their name must also be present. Staff educated to never put anything in the refrigerator, freezer or cupboards that do not meet these requirements. Reminded that many times residents themselves put things in there so it is up to staff to monitor and QA constantly. 9/23/2021 an additional check/sign off twice daily was put in place that will be done when staff checks and document the refrigerator and freezer temperatures. Effective immediately there is a QA sign off to complete for the remainder of September and beginning with the October 1, 2021 temperature checks there will be the additional responsibility when you initial that you

103g - Storing Food (continued)

have checked and no food is found to be out of compliance. Food found to be out of compliance will be disposed of immediately. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

103i - Outdated Food

1. Requirements

2600.
103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On 8/5/21, there was an uncovered and unlabeled/undated bowl of chocolate ice cream in the freezer section of the white refrigerator/freezer in the kitchenette.

Plan of Correction ***Accept***

All staff reeducated that food must be covered or in a sealed container and all food has to have a date on it as well as that if food belongs to a specific resident, their name must also be present. Staff educated to never put anything in the refrigerator, freezer or cupboards that do not meet these requirements. Reminded that many times residents themselves put things in there so it is up to staff to monitor and QA constantly. 9/23/2021 an additional check/sign off twice daily was put in place that will be done when staff checks and document the refrigerator and freezer temperatures. Effective immediately there is a QA sign off to complete for the remainder of September and beginning with the October 1, 2021 temperature checks there will be the additional responsibility when you initial that you have checked and no food is found to be out of compliance. Food found to be out of compliance will be disposed of immediately. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

121a - Unobstructed Egress

1. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On 8/5/21, the fire exit door exiting from the dining area to the gazebo area was stuck shut and would not open when pushed. The bottom corner of the door and the door jamb/threshold were rusted.

Plan of Correction ***Accept***

Maintenance immediately came over the day of inspection. They checked the hinges, shimmed/made adjustments and filed away as much rust as possible to ease in the operation of the door. September 23 it was reported to me that maintenance has been in contact with a local company. The company is expected to come next week to inspect and measure the door and frame. We will have a new door and frame ordered to those specifications and installed upon it's arrival. A quote was received 10/21/2021 and order placed with the expected delivery date of "a couple weeks". A temporary repair of the wall is in progress. Upon the tearing out and instillation of the new door and frame, maintenance will be able to further assess and complete the final repairs to the surrounding wall at the base. Those dates are unknown as it is dependent on the ordering, arrival and replacement of the door and frame. Direct care staff has been educated as to upon manually locking and unlocking the exit doors daily to be mindful of the

121a - Unobstructed Egress (continued)

ease in operation and immediately fill out a maintenance slip to report any difficulties. The updated shipping information of the door is now 2/10/2022, maintenance director is scheduled to call on 2/11/22 to receive an "install date" from the company. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

181f - Record of Medication

1. Requirements

2600.
181.f. The resident's record shall include a current list of prescription, CAM and OTC medications for each resident who is self-administering his medication.

Description of Violation

On 8/There was a [redacted] bedside table for self administration. However, the home had no record of the resident currently self administering this medication.

Plan of Correction ***Accept***

The drops were immediately removed from [redacted] room, [redacted] was spoken to and [redacted] stated [redacted] son brought them in on his visit that day, [redacted] didn't want or need them as [redacted] has eye drops that are already ordered. The eye drops were given back to family to remove from the facility and take home. 8/13/2021 this resident as well as all other residents were reminded 1:1 and reeducated on the regulations and they signed off understanding. We will continue the reminders and are adding a verbal reminder during the monthly resident council meeting. Staff reeducated as to every medication whether prescription, OTC, kept in the med room or at bedside must be documented and the use of it has to be ordered by a physician. If deemed capable, some residents may have medications kept locked in their nightstand at bedside. Nothing is ever permitted in a room without an order that specifically states "may keep at bedside".

Continue with already existing quarterly QA for bedside medications assuring that each has a matching order and no med is present without a matching order. SEE ATTACHED

Completion Date: 08/13/2021

Document Submission ***Implemented***

SEE ATTACHED

184a - Labeling OTC/CAM

1. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #2 is prescribe [redacted] CALL DOCTOR.

However, the sliding scale was not indicated on the pharmacy label.

Plan of Correction ***Accept***

A recently signed physician order containing the sliding scale was immediately copied and attached to the insulin

184a - Labeling OTC/CAM (continued)

and SMP pharmacy was contacted. That same day, the pharmacy created small labels that lists the sliding scale. They agreed to place a label on each box of insulin ordered moving forward and also supplied RCC with several labels in the event that one is absent or falls off that we may put one on. RCC staff has been educated that the sliding scale is part of the dosage and instructions necessary on a pharmacy label. Staff acknowledges to every administration done using the 3 checks and being mindful that the scale is present, correcting it if it isn't and reporting it to [redacted] if it is found missing again. QA done 9/20/2021 shows scale present on the current box of insulin. SEE ATTACHED
Completion Date: 08/06/2021

A task to audit the pharmacy label has been added to the QMAR to assure that any sliding scale ordered for the residents is present and visible on the insulin label/container. The task will be completed every 28 days. The audit began immediately and will routinely occur moving forward. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

185a - Implement Storage Procedures

1. Requirements

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 #2's glucometer was not calibrated to the correct time.

Plan of Correction ***Accept***

The time has been updated and as of a QA completed 9/22/2021 is now correct. Audit on all resident glucometers done 9/22/2021 show to be set for the correct time and date. Staff educated as to every time you use a glucometer it is your responsibility to be sure that not only the readings are documented true and accurate but that the date and time settings are as well. Documentation is being added to the already existing quarterly QA that of "glucometers versus entries on the MAR". There will now be an acknowledgement of date and time accuracy. If at any time it is found to have inaccuracies, whether during daily use or during the quarterly QA, it is staff responsibility to fix it immediately, if unsure how to ask for help or bring it to the attention of Michele to assist. RCC staff acknowledges that the time change every spring and fall will need to be adjusted for as well as each time there is a change of batteries. SEE ATTACHED

Completion Date: 09/22/2021

A task to audit the glucometers for accurate time has been added to the QMAR to assure that all residents' meters are correct for the record. The task will be completed every week. The audit began immediately and will then be routinely occurring on Saturdays moving forward. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED

187a - Medication Record

1. Requirements

187a - Medication Record *(continued)*

2600.

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

5. Dosage form.
6. Dose.
8. Frequency of administration.

Description of Violation

Resident #2 is prescribed [redacted] *CALL DOCTOR.*

However, the sliding scale was not indicated on the resident's August 2021 Medication Administration Record (MAR).

Plan of Correction ***Accept***

On the day of inspection the sliding scale wouldn't print on a paper MAR report even though it was present on the e-mar with every administration and electronic MAR is what we use. 8/11/2021 an additional safeguard was added to the medication description in the way of an "order note". The entire sliding scale chart now appears in the description box with every administration as well as the electronic scale that was already present automatically prompting the individual administering medication how much insulin is necessary to follow the scale based on the glucometer reading that is entered. The entire sliding scale will also print on a paper MAR report just as it always has on the physician's order forms/medication lists. An additional part will be added to our quarterly QA, while checking that all medications have a diagnosis we will also acknowledge that any/all resident having sliding scale insulin also have the addition of an "order note" present and showing with the medication description box. SEE ATTACHED

Completion Date: 08/11/2021

A task to audit the record has been added to the QMAR to assure that any sliding scale ordered for the residents is present and visible on the record. The task will be completed every 28 days. The audit began immediately and will routinely occur moving forward. SEE ATTACHED

Document Submission ***Implemented***

SEE ATTACHED