

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

April 25, 2023

[REDACTED]
LUTHERAN HOME AT KANE
100 HIGH POINT DRIVE
KANE, PA, 16735

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 01/18/2023, 01/20/2023 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,

[REDACTED]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: LUTHERAN HOME AT KANE/RESIDENTIAL CARE CENTER
Address: 100 HIGH POINT DRIVE, KANE, PA 16735
County: MCKEAN **Region:** WESTERN
License #: 42645 **License Expiration:** 11/10/2023

Administrator

Name: [REDACTED] **Phone:** [REDACTED] **Email:** [REDACTED]

Legal Entity

Name: LUTHERAN HOME AT KANE
Address: 100 HIGH POINT DRIVE, KANE, PA, 16735
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: C 1 **Date:** 05/23/1980 **Issued By:** Dept. of Labor & Industry

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 21 **Waking Staff:** 16

Inspection Information

Type: Partial **Notice:** Unannounced **BHA Docket #:**
Reason: Complaint **Exit Conference Date:** 01/20/2023

Inspection Dates and Department Representative

01/18/2023 On Site [REDACTED]
 01/20/2023 Off Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 33 **Residents Served:** 21

Secured Dementia Care Unit

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

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 6 **Are 60 Years of Age or Older:** 20
Diagnosed with Mental Illness: 10 **Diagnosed with Intellectual Disability:** 2
Have Mobility Need: 0 **Have Physical Disability:** 0

Inspections / Reviews

01/18/2023 - Partial

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 02/11/2023

Inspections / Reviews *(continued)*

03/01/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/06/2023

Reviewer: [REDACTED]

Follow-Up Type: POC Submission

Follow-Up Date: 03/07/2023

03/30/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 04/06/2023

Reviewer: [REDACTED]

Follow-Up Type: Document Submission Follow-Up Date: 04/06/2023

04/25/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 04/06/2023

Reviewer: [REDACTED]

Follow-Up Type: Not Required

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On [REDACTED]/22, resident #1 entered the bedroom [REDACTED] shares with resident #2, sat on resident #2's bed, put [REDACTED] arm around [REDACTED] and kissed [REDACTED] on the forehead. Resident #2 pushed resident #1 away and told [REDACTED] not to do that. In [REDACTED] resident #1 asked resident #2 "Are you still masturbating," and told another resident that resident #2 is masturbating and all resident #2 needs now is [REDACTED]. Resident #1 admits to repeatedly patting resident #2 [REDACTED], even though resident #2 asked [REDACTED] to stop. These interactions made resident #2 uncomfortable.

Plan of Correction

Accepted [REDACTED] - 03/30/2023)

Resident #2 shared [REDACTED] encounter with a staff member late on [REDACTED] 2022 who while active listening was documenting [REDACTED] statement of what had occurred. Staff member reported to PCHA via text and phone call. Upon waking in the morning (7:15am) PCHA asked resident #1 to the office where [REDACTED] was asked open ended questions in the presence of another staff member sitting silent as only a witness to the interview. [REDACTED] voluntarily told of and confirmed all but the "masturbating and [REDACTED] parts of the allegations. [REDACTED] am verbal was made to Protective services, [REDACTED] call to resident #2 designated person notified, [REDACTED] resident #1 designated person notified, [REDACTED] verbal message to DHS for call back, written reports to Protective Services and DHS at [REDACTED] and [REDACTED] am fax completed. Resident #1 already has very involved family consisting of a brother and sister in law. Lengthy 1:1 conversation resulted in agreement to not leaving this wing, [REDACTED] agreed that [REDACTED] would spend time in [REDACTED] own room or common areas, [REDACTED] chose to not visiting other residents in their rooms, not touching others and keeping [REDACTED] hands to [REDACTED] what [REDACTED] saw as a "joke" others found offensive, and [REDACTED] agreed that we were going to be seeing [REDACTED] face to face every 15 minutes (and we did this from 11/2/2022-11/30/2022. Protective Services came [REDACTED] to begin their investigation of the reported incident. The morning after resident #2 told staff [REDACTED] story [REDACTED] attempted to recant it but we had already taken action in reporting and informing both families and [REDACTED] told us [REDACTED] was angry about that. [REDACTED] insisted to RCC and to Protective Services that [REDACTED] did not want [REDACTED] roommate to get in trouble, [REDACTED] did not want to lose [REDACTED] roommate, [REDACTED] is [REDACTED] friend and is "turning in to a [REDACTED] [REDACTED] went as far as to "sign off" on the complaint with the understanding that "things could escalate" [REDACTED] stated [REDACTED] "only wanted [REDACTED] to stop then" and [REDACTED] did. Regardless of resident #2's wishes a decision was still made by PCHAs to remove resident #1 from the room and put [REDACTED] in a different room at the other end of the hall on [REDACTED]/2022, biweekly appointments with the Guidance Center for medication review/therapy with [REDACTED] psych CRNP were agreed upon and [REDACTED] had appointments [REDACTED], [REDACTED] (which was cancelled by the office and rescheduled for [REDACTED] 2023) At 1/3/2023 appointment the biweekly CRNP appointments were changed to monthly and the addition of a counseling appointment was added also. These are February 7 and 10 respectively. 1/18/2023 DHS arrived to conduct their investigation and conduct their interviews related to this complaint Documentation now consists of "by exception" any time resident #1 is off the wing for an activity or on an outing/appointment where staff has no visual. There have been no further "issues" between the two or any others and when asked resident #2 repeatedly always states feeling safe. All staff is trained upon their individual date of hire by Human Resources Department, again annually at an in-service facility wide training by the Social Services Director, every facility employee is scheduled yearly by their immediate supervisors to attend during a date in their designated month, and PCH staff are trained again at least once annually specific to PCH regulations 2600 related to what is, what to do, when/how and reporting of abuse by the PCHAs which had been in May 2022. The entire facility was also updated in regards to DOH regulations relating to resident abuse and sexually inappropriate behaviors in November 2022. Staff members read, were provide small group or 1:1 guidance by direct supervisors and signed off on the information during dates as they were assigned to work. This practice

42b - Abuse (continued)

will continue and will remain the responsibility collectively of these department Directors and their Designees to continue to provide the guidance and training. Appointments will continue with the psych CRNP and counselor as they feel necessary for resident #1 mental and behavioral health

Licensee's Proposed Overall Completion Date: 03/06/2023

Implemented (█ - 04/25/2023)

227d Support Plan Medical/Dental**2. Requirements**

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 #1, dated █/22, indicates the resident has a need for psychological services. The resident's support plan, dated █, does not document the monthly visitation with the psych nurse that began in █2022.

Plan of Correction

Accept (█ - 03/30/2023)

Many steps were taken both immediately as well as progressively to assure supervision, safety, medical, emotional and behavioral needs were met for this resident as well as the other impacted. █/2023 an addition to the RASP was added to describe the changes/increases in care being provided as well as addition frequency of appointments. All staff is responsible to add updates to RASP when there is a significant change. An review was started 1/19/23 and has since been completed on all resident RASPs for needed updates by PCHAs and designated staff and quarterly QA will be the responsibility of an Assigned Designee to review resident list for any significant changes to assure that all updates have been made as they've occurred. PCH staff receives yearly training related to pre-assessments, DMEs, RASPs and adding updates. this took place June 2022 by the PCHAs. A small group and 1:1 training was again presented by PCHA as a reminder to PCH staff that changes in resident care needs must be reflected on the RASP in the form of updates. This was initiated 3/2/2023 and is being completed on dates as staff is scheduled to work.

Licensee's Proposed Overall Completion Date: 03/10/2023

Implemented (█ 04/25/2023)