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

August 16, 2023

[redacted], ADMINISTRATOR
CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH
1600 GEORGETOWN DRIVE
SEWICKLEY, PA, 15143

RE: CONCORDIA OF FRANKLIN PARK
1600 GEORGETOWN DRIVE
SEWICKLEY, PA, 15143
LICENSE/COC#: 44363

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/11/2023, 07/12/2023 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: *CONCORDIA OF FRANKLIN PARK* **License #**: *44363* **License Expiration**: *03/15/2024*

Address: *1600 GEORGETOWN DRIVE, SEWICKLEY, PA 15143*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*

Address: *1600 GEORGETOWN DRIVE, SEWICKLEY, PA, 15143*

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *06/04/1999* **Issued By**: *Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *76* **Waking Staff**: *57*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *07/12/2023*

Inspection Dates and Department Representative

07/11/2023 - On-Site: [redacted]

07/12/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *63*

Secured Dementia Care Unit

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

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *63*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *13* **Have Physical Disability**: *1*

Inspections / Reviews

07/11/2023 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/29/2023*

Inspections / Reviews *(continued)*

07/31/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2023*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/07/2023*

08/07/2023 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2023*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/14/2023*

08/16/2023 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/14/2023*

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

53a Qualifications

1. Requirements

2600.
53.a. The administrator shall have one of the following qualifications:
1. A license as a registered nurse from the Department of State.
2. An associate's degree or 60 credit hours from an accredited college or university.
3. A license as a licensed practical nurse from the Department of State and 1 year of work experience in a related field.
4. A license as a nursing home administrator from the Department of State.
5. For a home serving 8 or fewer residents, a general education development diploma or high school diploma and 2 years direct care or administrative experience in the human services field.

Description of Violation

Staff person A, [redacted], does not have documentation of 60 or more credits from an accredited college or university.

Plan of Correction ***Directed ([redacted] - 08/07/2023)***

Staff person A received transcripts from [redacted] University on [redacted] providing proof of completion of 60 credit hours from an accredited college or university and provided a copy of same to DHS on 7/28/2023. . Administrator to audit 5 employee files monthly to ensure accuracy starting on 8/7/2023 and continuing for 90 days. See audit form.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall maintain all documentation in accordance with Regulation 2600.53(a) in the administrator's record and have it available to the Department upon request. 8/7/23 [redacted]

Directed Completion Date: *08/08/2023*

Implemented [redacted] - 08/16/2023)

85a Sanitary Conditions

2. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 7/11/23, at 10:13 a.m., there was a used washcloth on the sink in the common bathroom across from room GN105.

Plan of Correction ***Accept ([redacted] - 07/31/2023)***

On 7/11/23 Administrator removed used wash cloth from sink in common bathroom across from GN105. Administrator gave verbal education to staff members on sanitary conditions on 7/11/2023. Rounds to be completed daily by administrator or designee starting on 7/31/2023 for cleanliness and sanitary conditions are met. These rounds and documentation of them will be continued for 60 days. Any issues found during the rounds will be addressed immediately by the person completing the rounds.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented [redacted] - 08/16/2023)

85e Trash Outside Home

3. Requirements

85e Trash Outside Home *(continued)*

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

On 7/11/23, at approximately 10:00 a.m., there was a wheeled cart outside of the gardens west door that was uncovered and filled with a pop can, a Kona ice cup, various pieces of trash, and several inches of water.

Plan of Correction ***Directed [redacted] - 08/07/2023)***

The wheeled cart outside of the gardens west door was removed and cleaned by Maintenance staff on 7/11/2023. Administrator conducted verbal education to staff members on ensuring clean and sanitary conditions for the facility on 7/14/2023. The wheeled carts are no longer in use at the facility starting on 7/11/2023 at the request of the Administrator. See education form.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the outside of the home weekly to ensure compliance with Regulation 2600.85(e). Documentation of audits shall be kept. 8/7/23 JK

Directed Completion Date: *08/08/2023*

Implemented [redacted] - 08/16/2023)

103i Outdated Food

4. Requirements

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

Description of Violation

On 7/11/23, at 10:33 a.m., there was a 6 lb. 11 oz. dented can of Manwich on the shelf in the first floor dry food storage area.

Plan of Correction ***Accept [redacted] - 08/07/2023)***

On 7/11/2023 surveyor found the dented can of Manwich on the shelf in first floor storage room, this was promptly removed by Administrator. Administrator gave verbal education to dietary manager and dietary staff on 7/12/2023 on the removal of these items from the shelves. Dietary manager will be doing rounds on food delivery days starting on 7/31/2023 and continuing for 60 days. Administrator will audit rounds sheets weekly starting on 8/7/2023 and continuing for 60 days. See education.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented ([redacted] - 08/16/2023)

121a Unobstructed Egress

5. 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

The emergency exit leading from the doorway next to the formal dining room to the main parking lot was blocked with scaffolding and caution tape due to construction taking place on the concrete bridge just outside the door.

121a - Unobstructed Egress *(continued)*

Plan of Correction ***Directed (- 08/07/2023)***

Bridge restoration has been ongoing for the months of June and July, on 7/11/2023 surveyor noted that the fire exit leading to the front parking lot was block with scaffolding and caution tape. At the request of the surveyor, Administrator placed a "temporarily not an exit" sign on the door leading out this exit on 7/11/2023. Staff were informed by Administrator on 7/13/23 of the proper usage of egress routes to use instead of the door that is temporarily inaccessible. Staff notice and exit being temporally closed and also staff training about the temporary closing and what exit routes to use. In-person training to be conducted by facility fire safety person and documented for education. See education.

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall contact the local code enforcement officer and notify the code enforcement office of the emergency exit being unusable and follow the directions of the code enforcement officer. Documentation of the code enforcement officers directions shall be kept. 8/7/23

DIRECTED
Within 1 calendar day of receipt of the accepted plan of correction: The administrator shall audit the home weekly to ensure all stairways, hallways, doorways, passageways and egress routes from rooms and from the building to are unlocked and unobstructed. Documentations of checks shall be kept. 8/7/23

Directed Completion Date: *08/08/2023*

Implemented (- 08/16/2023)

123b - Emergency Procedures Posted

6. Requirements

2600.
123.b. Copies of the emergency procedures as specified in § 2600.107 (relating to emergency preparedness) shall be posted in a conspicuous and public place in the home and a copy shall be kept.

Description of Violation

On 7/11/23 and 7/12/23, the home's emergency procedures were not posted in a conspicuous and public place in the home.

Plan of Correction ***Directed - 08/07/2023)***

On 7/11/2023 and 7/12/2023 surveyor noted that the emergency procedures binder was not in a conspicuous and public location. Administrator placed this binder next to the bulletin board off of the main dining room in an envelope holder on 7/12/2023. Continued compliance on this placement will be verified during daily rounds by the Administrator or designee for 60 days starting on 7/31/23. See education of new location.

DIRECTED
Within 5 calendar days of receipt of the accepted plan of correction: The administrator shall educate all staff persons on the location of the emergency procedures. Documentation of education shall be kept. 8/7/23 JK

Directed Completion Date: *08/12/2023*

Implemented (- 08/16/2023)

132a - Monthly Fire Drill

7. Requirements

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 8/2022.

Plan of Correction ***Accept (- 07/31/2023)***

On 7/12/2023 surveyor alerted Administrator to an unannounced fire drill was not conducted during August of 2022. When meeting with the maintenance director this was not conducted due to COVID-19 outbreak in this facility. Education provided to maintenance director on requirements for monthly drills on 7/12/23. Administrator to audit the fire drills monthly starting on 7/31/2023 for 90 days.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented - 08/16/2023)

132c - Fire Drill Records

8. Requirements

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 on 7/26/22 does not include the number of staff participating in the drill.

Plan of Correction ***Accept (- 08/07/2023)***

On 7/12/2023 surveyor noted the fire drill on 7/26/2022 did not have the number of staff members present for this fire drill were not listed on the form. Administrator gave verbal training to maintenance director on 7/12/23 on the proper use of the fire drill form. Administrator to conduct audits of these forms on a monthly basis with maintenance director for 90 days starting on 7/31/23. See audit tool.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented 08/16/2023)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The last fire drill conducted during sleeping hours was on 6/27/23 at 5:45 a.m. The previous sleeping hours fire drill was conducted on 11/10/22.

Plan of Correction ***Accept (- 07/31/2023)***

On 7/12/2023 surveyor noted that fire drills during sleeping hours will be conducted every six months. Maintenance director notified and educated by administrator of the fire drills being conducted during sleeping hours needing to be completed every 6 months on 7/13/2023. Moving forward maintenance director will be conducting sleeping hours fire drills quarterly with Administrator auditing the fire drills monthly with Maintenance director. These audits will

132e - Fire Drill Sleeping Hours (continued)

continue for 90 days starting 7/31/23.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented (- 08/16/2023)

141b1 - Annual Medical Evaluation

10. Requirements

2600.
141.b.1. A resident shall have a medical evaluation: At least annually.

Description of Violation

Resident #1's most recent medical evaluation was completed on however, the resident's previous medical evaluation was completed on

Plan of Correction ***Accept (- 07/31/2023)***

On 7/11/2023 surveyor noted that resident #1's most recent medical evaluation was conducted on and the previous evaluation was completed on . Resident Care Coordinator's were educated by Administrator on proper scheduling of medical evaluations on . Resident Care Coordinators will develop a plan to maintain the annual resident assessments. Resident Care Coordinators will monitor this plan for resident assessments monthly and report the upcoming assessments due, to the Administrator on a monthly basis. These monthly audits will be maintained for 90 days starting and documentation of those audits handed in to the administrator for review.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented - 08/16/2023)

184a - Resident's Meds Labeled

11. 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 prescribed g-Take 1 tablet by mouth every 6 hours as needed. However, the pharmacy label indicates-Take 2 tablets by mouth every 6 hours as needed.

Resident #3 is prescribed -Give 1 capsule by mouth every morning and at bedtime. However, the pharmacy label indicates-60mg tablets, Give 2 tablets every morning and at bedtime.

Plan of Correction ***Accept (- 07/31/2023)***

On 7/12/2023 surveyor noted that resident #2's instructions are incorrect on the pharmacy label compared to what the resident was ordered. Upon notification of this, the Resident Care Coordinator placed a Change of Direction sticker on the pharmacy label for this resident #2's medication card on 7/12/2023. Resident #3's medication was incorrectly labeled on the pharmacy label. Upon notification of this, Resident Care Coordinator placed a Change of Direction sticker on the pharmacy label on 7/12/2023. Resident Care Coordinator's or designee to audit medication carts every two weeks for medication accuracy and pharmacy label accuracy starting on 8/7/2023 and continuing for 90 days. Any issues found with audits will be addressed

184a - Resident's Meds Labeled (continued)

immediately and documentation of audits turned in to Administrator for review.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented (- 08/16/2023)

187d - Follow Prescriber's Orders

12. Requirements

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

Description of Violation

On 6/23/23, resident #1 was prescribed [redacted] subcutaneously one time a day every Monday. However, this medication was never administered to the resident because the medication was not available in the home.

Plan of Correction ***Accept (- 08/07/2023)***

On 7/12/2023, resident #1's [redacted] was found to not be administered to resident. Upon notification of this, Resident Care Coordinator discontinued the order for resident #1 with the approval from rounding CRNP on 7/12/2023. Resident Care Coordinator's to audit medication carts every two weeks for medication accuracy and pharmacy label accuracy starting on 8/7/2023 and continuing for 90 days. Medication not available training to be conducted for all medication administration staff. See education.

Licensee's Proposed Overall Completion Date: *08/07/2023*

Implemented - 08/16/2023)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.

Description of Violation

Resident #1's most recent assessment was completed on [redacted]; however, the resident's previous assessment was completed on [redacted].

Plan of Correction ***Accept - 07/31/2023)***

On 7/11/2023 surveyor noted that resident #1's most recent assessment was conducted on [redacted] and the previous evaluation was completed on [redacted] Resident Care Coordinators were educated by Administrator on proper scheduling of assessments on [redacted] Resident Care Coordinators will develop a plan to maintain the annual resident assessments starting on [redacted]. Resident Care Coordinators will monitor this plan for resident assessments monthly and report the upcoming assessments due to the Administrator on a monthly basis. These monthly audits will be maintained for 90 days starting on [redacted] and documentation of those audits will be handed in to the administrator for review.

Licensee's Proposed Overall Completion Date: *07/31/2023*

Implemented (- 08/16/2023)