

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

August 3, 2023

[REDACTED], ADMINISTRATOR
DIAKON LUTHERAN SOCIAL MINISTRIES
800 HAUSMAN ROAD
ALLENTOWN, PA, 18104

RE: LUTHER CREST RETIREMENT
COMMUNITY
800 HAUSMAN ROAD
ALLENTOWN, PA, 18104
LICENSE/COC#: 21629

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/27/2023 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]
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: LUTHER CREST RETIREMENT COMMUNITY **License #:** 21629 **License Expiration:** 07/30/2023
Address: 800 HAUSMAN ROAD, ALLENTOWN, PA 18104
County: LEHIGH **Region:** NORTHEAST

Administrator

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

Legal Entity

Name: DIAKON LUTHERAN SOCIAL MINISTRIES
Address: 800 HAUSMAN ROAD, ALLENTOWN, PA, 18104
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 11 **Date:** 11/08/2013 **Issued By:** S Whitehall Twp

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 37 **Waking Staff:** 28

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal, Complaint **Exit Conference Date:** 06/27/2023

Inspection Dates and Department Representative

06/27/2023 On Site [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 71 **Residents Served:** 24

Secured Dementia Care Unit

In Home: Yes **Area:** MSU **Capacity:** 13 **Residents Served:** 11

Hospice

Current Residents: 0

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 24
Diagnosed with Mental Illness: 0 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 13 **Have Physical Disability:** 0

Inspections / Reviews

06/27/2023 - Full

Lead Inspector: [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 07/23/2023

07/27/2023 - POC Submission

Submitted By: [REDACTED] **Date Submitted:** 08/03/2023
Reviewer: [REDACTED] **Follow-Up Type:** Document Submission **Follow-Up Date:** 08/01/2023

Inspections / Reviews *(continued)*

08/03/2023 - Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/03/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

3c - Post Current License

1. Requirements

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

The most recent LIS from [redacted]/2023 was not posted conspicuously in the home.

Plan of Correction

Accept [redacted] - 07/27/2023)

- 1. The personal care home immediately posted the updated current license summary for review.
- 2. The PCHA or designee will update the current license summary binder within 24 hours upon exit of DHS from the facility. PCHA and CMS were provided education that current license summary binder must be updated upon every DHS visit.
- 3. [redacted] PCHA, will update current license summary binder with every visit from DHS.
- 4. Target completion Date: 8/31/2023
- 5. PCHA or designee will audit current license summary binder weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved. Corrective action plan will be monitored through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ([redacted] - 08/03/2023)

85d - Trash Receptacles

2. Requirements

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

There was no lid on the garbage can located in the kitchen in the secured dementia unit.

Plan of Correction

Accept ([redacted] - 07/27/2023)

- 1. Lid was immediately placed on garbage can located in the kitchen in the secure dementia unit.
- 2. Dietary manager or designee will audit garbage can in the kitchen in the secure dementia to ensure the lid is in place. The Dietary manager will provide staff with education that garbage can in kitchen shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.
- 3. [redacted] Dietary Manager
- 4. Target Completion date: 8/31/2023
- 5. Dietary Manager or designee will audit garbage can lid in the secure dementia unit weekly x 4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure lid is in place. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ([redacted] - 08/03/2023)

141a 1-10 Medical Evaluation Information

3. Requirements

2600.

141a 1-10 Medical Evaluation Information (continued)

- 141.a. A resident shall have a medical evaluation by a physician, physician’s assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:
1. A general physical examination by a physician, physician’s assistant or nurse practitioner.
 2. Medical diagnosis including physical or mental disabilities of the resident, if any.
 3. Medical information pertinent to diagnosis and treatment in case of an emergency.
 4. Special health or dietary needs of the resident.
 5. Allergies.
 6. Immunization history.
 7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
 8. Body positioning and movement stimulation for residents, if appropriate.
 9. Health status.
 10. Mobility assessment, updated annually or at the Department’s request.

Description of Violation

The DME dated [REDACTED]/2023 for Resident 1 is incomplete. The required section on self-administering medications was left blank.

Plan of Correction

Accept ([REDACTED] - 07/27/2023)

1. DME for Resident 1 was updated/completed including the section on self-administering medications.
2. The CSM or designee will complete whole house audit to ensure the Self-Administering medication section is completed. CSM or designee will provide staff with education on how to complete DME.
3. [REDACTED] CSM
4. Target completion date: 8/31/2023
5. CSM or designee will audit newly completed DMEs weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure self-administering medication section is completed. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented ([REDACTED] - 08/03/2023)

184b - Labeling OTC/CAM

4. Requirements

2600.

184.b. If the OTC medications and CAM belong to the resident, they shall be identified with the resident’s name.

Description of Violation

The bottle of Centrum Men’s Vitamins for Resident 2 was not labeled with the resident’s name, only a room number.

Plan of Correction

Accept ([REDACTED] - 07/27/2023)

1. The bottle of Centrum Men’s Vitamins for Resident 2 was labeled with residents’ name and room number.
2. The CSM or designee will complete whole med cart audit to ensure all medication have both residents name and room number. The CSM or designee will provide staff with education that all medications in the medication cart must have residents name and room number on medication bottle.
3. [REDACTED] CSM
4. Target completion date: 8/31/2023
5. CSM or designee will audit medication cart weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure all medications have both resident name and room number. Corrective action plan will be monitor through QAPI process.

184b - Labeling OTC/CAM (continued)

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (MM - 08/03/2023)

185a - Implement Storage Procedures

5. 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 3's glucometer was not calibrated to the correct date and time.

Resident 4 is prescribed [redacted] every 6 hrs. PRN. The medication was not on hand at the time of inspection.

Plan of Correction

Accept (MM - 07/27/2023)

- 1. Resident #3 given new glucometer that was calibrated to show correct date and time. PRN Tylenol Extra Strength 500mg was obtained and placed in medication cart for resident use.
- 2. The CSM or designee will complete medication cart audit to ensure all resident who have order for PRN Tylenol have medication available in medication cart. The CSM or designee will provide staff education on how and when to calibrate glucometers and ensuring all PRN medications are available for resident use.
- 3. [redacted] CSM
- 4. Target completion date: 8/31/2023
- 5. CSM or designee will audit medication cart weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure all PRN Tylenol medication orders are available in medication cart for resident use. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented (MM - 08/03/2023)

187a - Medication Record

6. Requirements

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 5 is prescribed [redacted] tablet by mouth 3 times daily; hold if Systolic Blood Pressure (SBP) is over 140. On [redacted]/23 at [redacted] pm, their SBP was [redacted]. On [redacted] at [redacted] pm, their SBP was [redacted]. The medication was held on both dates and coded see notes, but the MAR does not indicate in the notes why it was held.

Plan of Correction

Accept (MM - 07/27/2023)

- 1. Medication administration documentation cannot be retroactivity corrected.
- 2. The CSM or designee will complete whole house audit for all residents on blood pressure medications with parameters to ensure proper documentation was completed if medication was held. The CSM or designee will provide education to staff on the 6 rights of medication administration.

187a - Medication Record (continued)

3. [REDACTED] CSM
4. Target completion date: 8/31/2023
5. CSM or designee will audit all residents with blood pressure medications with parameters weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure proper documentation was completed if medication was held. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 08/03/2023)

187d Follow Prescriber's Orders**7. Requirements**

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

Description of Violation

Resident 5 is prescribed [REDACTED] by mouth 3 times daily; hold if Systolic Blood Pressure (SBP) is over 140. On [REDACTED] at [REDACTED] pm, their SBP was [REDACTED] and on [REDACTED] at [REDACTED] their SBP was [REDACTED]. The MAR indicates the medication was administered on both dates and times.

Plan of Correction

Accept [REDACTED] - 07/27/2023)

1. Medication administration error cannot be retroactivity corrected.
2. The CSM or designee will complete whole house audit for one months' time for all residents on blood pressure medications with parameters to ensure medication was held if blood pressure was not within parameters. The CSM or designee will provide education to staff on the 6 rights of medication administration.
3. [REDACTED], CSM
4. Target completion date: 8/31/2023
5. CSM or designee will audit all residents with blood pressure medications with parameters weekly x4 weeks, then monthly x2 months, or until substantial compliance is achieved to ensure proper medication was held if blood pressure was not within parameters. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 08/03/2023)

233d Electronic/Magnetic System**8. Requirements**

2600.
233.d. Doors that open onto areas such as parking lots, or other potentially unsafe areas, shall be locked by an electronic or magnetic system.

Description of Violation

The outdoor patio located in the secured dementia unit had an unlocked gate that led to an unsecured area of the home.

Plan of Correction

Accept [REDACTED] 07/27/2023)

1. The gait to the outdoor patio in the secure dementia unit was locked immediately upon being made aware.
2. The CSM or Designee will completed audits to ensure gait to outdoor patio in the secure dementia unit is locked. Staff provided education on ensuring gait in secure dementia unit is locked at all times.
3. [REDACTED] CSM

233d - Electronic/Magnetic System (continued)

4. Target completion date: 8/31/2023

5. CSM or designee will audit gate in outdoor patio of secure dementia unit weekly x4 weekly, then monthly x2 months, or until substantial compliance is achieved to ensure gate is locked. Corrective action plan will be monitor through QAPI process.

Licensee's Proposed Overall Completion Date: 08/31/2023

Implemented [REDACTED] - 08/03/2023)