

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

November 6, 2023

[REDACTED], ADMINISTRATOR  
CONCORDIA LUTHERAN HEALTH AND HUMAN CARE  
[REDACTED]

RE: CONCORDIA LUTHERAN HEALTH  
AND HUMAN CARE - LUND  
BUILDING  
134 MARWOOD ROAD  
CABOT, PA, 16023  
LICENSE/COC#: 44762

Dear [REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/22/2023 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 LUTHERAN HEALTH AND HUMAN CARE - License #: 44762 License Expiration: 10/27/2024  
LUND BUILDING

**Address:** 134 MARWOOD ROAD, CABOT, PA 16023

**County:** BUTLER **Region:** WESTERN

**Administrator**

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

**Legal Entity**

**Name:** CONCORDIA LUTHERAN HEALTH AND HUMAN CARE

**Address:** [REDACTED]

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

**Certificate(s) of Occupancy**

**Type:** C-1 **Date:** 11/25/1998 **Issued By:** Dept I & I

**Staffing Hours**

**Resident Support Staff:** 0 **Total Daily Staff:** 227 **Waking Staff:** 170

**Inspection Information**

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

**Reason:** Incident **Exit Conference Date:** 10/12/2023

**Inspection Dates and Department Representative**

09/22/2023 - On-Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**

**License Capacity:** 220 **Residents Served:** 195

**Secured Dementia Care Unit**

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

**Hospice**

**Current Residents:** 12

**Number of Residents Who:**

**Receive Supplemental Security Income:** 0 **Are 60 Years of Age or Older:** 190

**Diagnosed with Mental Illness:** 4 **Diagnosed with Intellectual Disability:** 0

**Have Mobility Need:** 32 **Have Physical Disability:** 5

**Inspections / Reviews**

09/22/2023 Partial

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

10/27/2023 - POC Submission

**Submitted By:** [REDACTED] **Date Submitted:** 10/31/2023

**Reviewer:** [REDACTED] **Follow-Up Type:** POC Submission **Follow-Up Date:** 11/03/2023

Inspections / Reviews (*continued*)

## 10/30/2023 POC Submission

Submitted By: [REDACTED]

Date Submitted: 10/31/2023

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/27/2023

## 11/06/2023 Document Submission

Submitted By: [REDACTED]

Date Submitted: 10/31/2023

Reviewer: [REDACTED]

Follow Up Type: Not Required

15a - Resident Abuse Report

1. Requirements

2600.

15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On [redacted] at approximately [redacted] p.m., an allegation of abuse was made to multiple staff that on [redacted], a male aid grabbed the resident by the shoulders, "shook" the resident and said "don't ever say that again". It was also reported that the resident struck the back of [redacted] head as well. The allegation of abuse was not reported to the local Area Agency on Aging until [redacted]/23 at [redacted]

Plan of Correction

Accept (J [redacted] - 10/27/2023)

Disagree with violation. Allegations of abuse was first reported to [redacted] Hospital Emergency Room personnel by resident's daughter on [redacted]. Trooper [redacted] came to facility to f/u with Allegation. Administrator was notified and arrived at facility. Administrator notified AAA, case manager [redacted] on 9/19/23 and completed ACT13 as well as submitting the incident reporting form on 9/19/23.

Resident's daughter reported to LPN on duty and manager on 9/17/23 that [redacted] had concerns and would like to speak with a manager. Manager met with daughter and informed her that her concerns would be followed up with and daughter would be notified in a.m. There was no mention of abuse at that time.

Allegation was reported to local AAA on [redacted] by Administrator.

Act13 was submitted on 9/19/23 to [redacted], Case Manager AAA

Investigation of incident was completed on [redacted] By Trooper [redacted], Administrator and Manager.

Initial reportable incident was completed and submitted by Administrator on 9/19/23 to DHS.

Education was provided to staff person A on 9/19/23 by Administrator and manager that any report of suspected abuse of a resident must be reported immediately to AAA and an Act13 form must be completed as well as notifying the Administrator/designee immediately. Staff person A was educated on the plan of supervision for remainder of shift and on going until case was closed.

Education on "Abuse and Abuse Reporting was provided to staff on 10/27/23 by Administrator and designee.

Administrator/designee will respond to all allegations of abuse as though the allegation was true and will report to the local AAA and DHS immediately.

Administrator/designee will follow up on all reported abuse allegations immediately to ensure compliance at time of occurrence.

see attached education.

Licensee's Proposed Overall Completion Date: 10/27/2023

Implemented ( [redacted] - 11/06/2023)

15b - Supervisor Plan

2. Requirements

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

15b Supervisor Plan (continued)

**Description of Violation**

On [REDACTED] an allegation of abuse was made against direct care staff person A; however, an approved plan of supervision was not submitted to the Department and staff person A worked [REDACTED]/23 from [REDACTED] p.m. [REDACTED] p.m. supervised and [REDACTED] p.m. [REDACTED] p.m. unsupervised.

**Plan of Correction**

Accept [REDACTED] - 10/30/2023)

Allegation of abuse was reported to Facility on [REDACTED] by [REDACTED] Neigh.

Staff person A was educated on 9/19/23 by administrator and manager, that "all abuse allegations must be reported immediately to ensure compliance at time of occurrence.

Administrator placed Staff person A immediately under direct supervision of Charge Nurse and NA on 9/19/23 Staff person A continued to be under supervision until results were received from DHS and AAA as to whether or not incident was substantiated or unsubstantiated.

A plan of supervision was then submitted to DHS on 9/22/23 by Assistant administrator and manager.

Staff person A was released from supervision per [REDACTED] on 10/10/23

Education was provided to Staff person A by Manager on the "General Procedure for moving a patient in Bed and Positioning" on 10/12/23

Education was provided to all nursing staff by Administrator and manager on 10/27/23 in regards to submitting a plan of supervision to DHS and employee can not work as a DCS until plan is approved by the department.

Administrator/designee will remove any DCS involved in allegation of abuse immediately at time of occurrence until plan of supervision is approved by the department. Policy reinforced on 9/19/23

Licensee's Proposed Overall Completion Date: 12/31/2023

Implemented [REDACTED] - 11/06/2023)

16c - Written Incident Report

**3. Requirements**

2600.

16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

**Description of Violation**

On [REDACTED], at approximately [REDACTED] p.m., an allegation of abuse was made to multiple staff that on [REDACTED]/23, a male aid grabbed the resident by the shoulders, "shook" the resident and said "don't ever say that again". It was also reported that the resident struck the back of her head as well. The home did not report the allegation of abuse or submit an incident report to the Department until 9/19/23 at 20:30.

**Plan of Correction**

Accept [REDACTED] - 10/30/2023)

Disagree with violation. Allegations of abuse was first reported to [REDACTED] Hospital Emergency room personnel by resident's daughter on [REDACTED]/23.

Administrator will report any/all allegations of abuse to the department's personal care home regional office or

16c - Written Incident Report (continued)

*the personal care home complaint hotline within 24 hours of incident. Policy reinforced 9/19/23.*

*Reportable incident form was completed and submitted to department on 9/19/23 by Administrator.*

*Administrator/designee will report any allegations of abuse and submit a Reportable incident to the department within 24hrs of occurrence. Policy reinforced 9/19/23*

*Education on Abuse and Abuse reporting was provided to staff on 10/27/23 by Administrator/managers*

*Administrator/designee will follow up on any reported abuse allegations to ensure compliance per policy. Policy reinforced on 9/19/23.*

*see attached educations*

**Licensee's Proposed Overall Completion Date: 12/31/2023**

**Implemented [REDACTED] - 11/06/2023)**

42c - Treatment of Residents

4. Requirements

2600.

42.c. A resident shall be treated with dignity and respect.

**Description of Violation**

*On [REDACTED]/23, Direct Care staff person A was assisting resident #1 with their bedtime routine. Resident #1 indicated staff person A was rough with the care which prompted the resident to state this aid would not make a good nurse. Staff person A allegedly grabbed the resident by the shoulder and said "don't ever say that again", while shaking the resident. Staff person A then lifted the residents leg up to transfer the resident into bed and that resident fell back and struck [REDACTED] head on the metal bar attached to the wall behind [REDACTED] bed; resulting in a bruise to the top of the residents head.*

**Plan of Correction**

**Accept [REDACTED] - 10/30/2023)**

*Staff person A was reeducated on the "general procedure for moving a resident in bed and positioning" by manager on 10/12/23.*

*Staff person A was educated on resident's right by Administrator on 10/27/23, "All resident's shall be treated with dignity and respect regardless of age, disability, or behavior. All residents are entitled to dignified and respectful treatment.*

*Staff person A is no longer assigned to care for resident #1 effective [REDACTED].*

*Administrator/designee will monitor staff persons daily and each shift as part of their regular duties to ensure dignity and respect is provided by all staff to all resident's at all times. Effective 9/19/23.*

*see attached.*

**Licensee's Proposed Overall Completion Date: 12/31/2023**

42c - Treatment of Residents (*continued*)

*Implemented (█ - 11/06/2023)*