

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

January 4, 2024

[REDACTED], ADMINISTRATOR
CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH
125 BROWN ROAD
WEXFORD, PA, 15090

RE: CONCORDIA OF WEXFORD
125 BROWN ROAD
WEXFORD, PA, 15090
LICENSE/COC#: 44362

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 11/06/2023, 11/13/2023 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 WEXFORD* License #: *44362* License Expiration: *08/27/2024*
 Address: *125 BROWN ROAD, WEXFORD, PA 15090*
 County: *ALLEGHENY* Region: *WESTERN*

Administrator

Name: [Redacted] Phone: [Redacted] Email: [Redacted]

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*
 Address: *125 BROWN ROAD, WEXFORD, PA, 15090*
 Phone: [Redacted] Email: [Redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *03/15/1994* Issued By: *L&I*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *39* Waking Staff: *29*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint* Exit Conference Date: *11/13/2023*

Inspection Dates and Department Representative

11/06/2023 - On-Site: [Redacted]
 11/13/2023 - On-Site: [Redacted]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *56* Residents Served: *35*

Secured Dementia Care Unit
 In Home: *No* Area: Capacity: Residents Served:

Hospice
 Current Residents: *5*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *35*
 Diagnosed with Mental Illness: *1* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *4* Have Physical Disability: *0*

Inspections / Reviews

11/06/2023 - Full
 Lead Inspector: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *12/07/2023*

12/08/2023 - POC Submission
 Submitted By: [Redacted] Date Submitted: *12/29/2023*
 Reviewer: [Redacted] Follow-Up Type: *POC Submission* Follow-Up Date: *12/14/2023*

Inspections / Reviews *(continued)*

12/15/2023 - POC Submission

Submitted By: [REDACTED]

Date Submitted: 12/29/2023

Reviewer: [REDACTED]

Follow-Up Type: *Document Submission* Follow-Up Date: 12/30/2023

01/04/2024 - Document Submission

Submitted By: [REDACTED] [REDACTED]

Date Submitted: 12/29/2023

Reviewer: [REDACTED]

Follow-Up Type: *Not Required*

54a - Direct Care Staff

1. Requirements

2600.

54.a. Direct care staff persons shall have the following qualifications:

- 2. Have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Description of Violation

Direct care staff person A, hired on [redacted]/23, does not have a high school diploma, GED or active registry status on the Pennsylvania nurse aide registry.

Plan of Correction

Directed ([redacted] - 12/15/2023)

The waiver for DCS person A to be cleared by the state to work in the building was submitted on 12/7/2023. Attached is [redacted] tuition bills from [redacted] proving [redacted] student enrollment status, as well as [redacted] international diploma and required classes and grades from [redacted] secondary school and DCS training. We have been using DCS from other Concordia facilities to help with staffing until waiver is approved since 11/21/2023. In the future, I will ask for high school diplomas before hiring, that way we'll have time to submit a waiver and get approval before we move forward with the full hiring process. (DIRECTED: By 12/30/23: The administrator shall develop and implement a new hire checklist to ensure qualifications specified in 2600.54a are obtained for each newly-hired direct care staff person prior to providing direct care services to any resident. Documentation of the checklist, as well as documentation of the qualifications specified in 2600.54a, shall be kept in each newly-hired direct care staff person's record. [redacted] 12/15/23). To ensure compliance in the future, I will complete employee file audits on the 28th of every month. All other DCS employee records have been checked and audited to ensure compliance with 2600.54.a on 12/11/2023 by me.

DIRECTED: Immediately: Staff person A cannot provide direct care services to any resident until the Department approves a waiver, or until additional documentation is submitted to the Department verifying a waiver is not needed. [redacted] 12/15/23

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/30/2023

Implemented ([redacted] - 01/04/2024)

60a - Staff/Support Plan

2. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On the morning of 9/28/23, there were 36 residents in the home, including 4 residents with mobility needs. Of the 4 residents with mobility needs, 2 residents require the assistance of staff persons to transfer in/out of bed/chair with the use of a sit-to-stand lift, and 1 resident requires the assistance of 2 staff persons to transfer in/out of bed/chair with the use of a Hoyer lift. However, from approximately 3:00 AM to 4:00 AM on 9/28/23, only 1 staff person was present in the home, which is not adequate to meet the needs of the residents and to evacuate all residents in the event of an emergency.

60a - Staff/Support Plan (continued)

Plan of Correction

Directed () - 12/15/2023)

As of 11/26/2023, we had one of our casual employees start to pick up a few midnight shifts every week to help out. I am still working on hiring another part time DCS aide to fill the rest of the midnight shifts throughout the week. Since 11/21/2023, I have been using an on-call schedule I created for the nights we only have two aides on midnight in case of an emergency. I have also been using some DCS from the sibling facilities through Concordia to help staffing shortages since 11/21/2023. And, I have been completing daily DCS schedule audits to make sure we have adequate staffing in accordance with our facility needs since 12/11/2023.

DIRECTED: Within 24 hours of receipt of the plan of correction: The administrator/designee shall review the direct care staffing schedule daily to ensure adequate staffing is provided in accordance with 2600.57b, 2600.57c, 2600.57d and 2600.60a. () 12/15/23

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/16/2023

Implemented () - 01/03/2024)

65e - 12 Hours Annual Training

3. Requirements

2600.

65.e. Direct care staff persons shall have at least 12 hours of annual training relating to their job duties.

Description of Violation

Direct care staff person B, hired on ()/19, only received 10 hours of annual training during the 2022 training year.

Plan of Correction

Directed () - 12/15/2023)

Staff person B has received the additional 2 hours of training that were due in 2022 on 7/16/2023, each is circled in the attached document. These were each one hour trainings. Attached is also () nursing license that () received on 11/20/2022. Documentation of the training will be kept in accordance with 2600.65i. To ensure each direct care staff person receives at least 12 hours of annual training each year, I will conduct monthly reports on the 15th of every month to make sure staff is staying up-to-date on their trainings starting 12/15/2023. I have also created a sign-out sheet on 11/27/2023 for staff to fill out once they have completed their training for the month, I will review this once a week. That way I can look at that and see who I may need to remind before the month is over. I started sending monthly reminders on 11/27/2023 on OnShift to all DCS to ensure compliance. I will also be completing a quarterly review of staff trainings and staff training plans to see where we stand as a building and for each department starting 12/27/2023 which is when our next QA management meeting will be held in accordance with 2600.26b. (DIRECTED: Documentation of the quality management reviews shall be kept, which includes the date/time of the meeting, who was present at the meeting and a summary indicating the topics discussed. () 12/15/23)

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/27/2023

Implemented () - 01/04/2024)

65f - Training Topics

4. Requirements

65f - Training Topics (continued)

2600.

65.f. Training topics for the annual training for direct care staff persons shall include the following:

- 3. Care for residents with dementia and cognitive impairments.
- 6. Safe management techniques.
- 7. Care for residents with mental illness or an intellectual disability, or both, if the population is served in the home.

Description of Violation

Direct care staff person B, hired on [REDACTED]/19, did not receive training on the following topics during the 2022 training year:

- Care for residents with dementia and cognitive impairments
- Safe management techniques
- Care for residents with a mental illness or an intellectual disability. On 11/6/23 and 11/13/23, the home served 1 resident with a mental illness.

Plan of Correction

Directed [REDACTED] - 12/15/2023)

Staff person B has received the three cited trainings on 12/12/2023, each training was an hour long and documentation of each will be kept in accordance with 2600.65i. All three trainings are attached to this POC. I started the monitoring steps on 11/27/2023 which is the monthly sign-out sheet employees fill out once they've completed their training for the month, I will review this once a week. I also started sending monthly reminders on 11/27/2023 on OnShift to all DCS to ensure compliance. I will also be conducting monthly audit reports on the 15th of every month starting 12/15/2023 to see where all my employees stand. I will also be conducting a quarterly review of staff trainings and staff training plans at the next quality management meeting on 12/27/2023. I will continue to hold these reviews in the quality management meetings in accordance with 2600.26b(3). (DIRECTED: Documentation of the quality management reviews shall be kept, which includes the date/time of the meeting, who was present at the meeting and a summary indicating the topics discussed. [REDACTED] 12/15/23)

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/27/2023

Implemented [REDACTED] - 01/04/2024)

65g - Annual Training Content

5. Requirements

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

- 2. Emergency preparedness procedures and recognition and response to crises and emergency situations.

Description of Violation

Direct care staff person B, hired on [REDACTED]/19, did not receive training on emergency preparedness procedures during the 2022 training year.

Plan of Correction

Directed [REDACTED] - 12/15/2023)

Staff person B received training on emergency preparedness on 7/16/2023. It is in the attachment to this POC and is a one hour training. Documentation of the training will be kept in accordance with 2600.65i. I gave [REDACTED] the same

65g - Annual Training Content (continued)

Emergency Preparedness training as a re-education on 12/1/2023 in person, which is attached in the LOC. And since 12/5/2023 I have incorporated the emergency preparedness procedure as part of the new-hire onboarding process, that way moving forward all new-hires will have it complete. The monitoring steps the facility will take include the monthly audit reports I will complete on the 15th of every month starting 12/15/2023. On 11/27/2023 I created the monthly sign-out sheet for employees to fill out once they've completed their training for the month, which I will review once a week. I also started sending monthly reminders on 11/27/2023 on OnShift to all DCS to ensure compliance. I will also be conducting a quarterly review of staff trainings and the staff training plans at the next quality management meeting on 12/27/2023. I will continue to hold these reviews in the quality management meetings in accordance with 2600.26b(3). (DIRECTED: Documentation of the quality management reviews shall be kept, which includes the date/time of the meeting, who was present at the meeting and a summary indicating the topics discussed. [REDACTED] 12/15/23)

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/27/2023

Implemented [REDACTED] - 01/04/2024)

86b - Bathroom

6. Requirements

2600.

86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

On 11/6/23, the exhaust fan in the ground level half bathroom near the kitchenette was inoperable. No operable, outside window was present in this bathroom.

Plan of Correction

Accept [REDACTED] - 12/15/2023)

The maintenance director was re-educated on 11/17/2023 as shown in the attachment. The broken exhaust fan was immediately following the first day of inspection on 11/7/2023 as shown in the attachment. All other bathroom fans were checked to ensure compliance with 2600.86b on 11/17/2023 by [REDACTED] maintenance director. The daily maintenance checks were implemented on 11/17/2023 and [REDACTED], maintenance director, is responsible to complete them and report findings to me. Items on the daily maintenance check include resident and common bathroom fans, resident and common bathroom water temperatures not reaching 120 degrees Fahrenheit, checking for flammable objects in the smoking designated area, portable space heaters in the building, extension cords, and tears in window screens.

Licensee's Proposed Overall Completion Date: 12/14/2023

Implemented [REDACTED] - 01/03/2024)

127a - Portable Space Heaters

7. Requirements

2600.

127.a. Portable space heaters are prohibited.

Description of Violation

On 11/6/23, a portable space heater was present in the home's tool room.

127a - Portable Space Heaters (continued)

Plan of Correction

Accept (█ - 12/15/2023)

The portable space heater was immediately removed from the building and later disposed on the first day of inspection on 11/6/2023. I completed a re-education training on the importance of resident safety and how space heaters are a fire hazard with the maintenance director on 11/17/2023. An inspection was conducted of the entire building including storage areas to ensure there are no other space heaters present in the home on 11/17/2023 by our maintenance director █. The daily checks were implemented on the same day as the re-education on 11/17/2023. The checks will be conducted by maintenance director █ checks resident and common bathroom fans, resident and common bathroom water temperatures not reaching 120 degrees Fahrenheit, checking for flammable objects in the smoking designated area, portable space heaters in the building, extension cords, and tears in window screens and reports any findings back to me.

Licensee's Proposed Overall Completion Date: 12/14/2023

Implemented (█ - 01/03/2024)

132g - Fire Drills Days/Times

8. Requirements

2600.

132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff persons during the 10:00 PM through 6:30 AM shift; however, the home has not conducted a fire drill with only 2 staff persons in the past year.

Plan of Correction

Directed (█ - 12/15/2023)

On 11/20/2023 at 6:30 PM our facility held a fire drill during the afternoon shift when there were only 2 employees in the building. On 12/5/2023 I created a spreadsheet with all the other drills we've done throughout the year. That way I have an easy resource to refer back to and check to make sure we are holding drills on different days of the week, at different times, not routinely with additional staff, and not routinely with low resident census. Attached is also the staff re-education piece I held on 12/11/2023 which all staff members received including nursing aides/med techs, nurses, activity aides/directors, housekeepers, and cooks. Documentation of the education will be kept in accordance with 2600.65i.

DIRECTED: Beginning on 12/18/23: The administrator shall review all fire drill records monthly to ensure fire drills are held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low. █ 12/15/23

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/18/2023

Implemented (█ - 01/03/2024)

144c2 - Smoking Area Distance

9. Requirements

2600.

144.c. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following:

- 2. A home that permits smoking inside or outside of the home shall develop and implement written fire safety policy and procedures that include the following: Location of a smoking room or outside smoking area a safe distance from heat sources, hot water heaters, combustible or flammable materials and away from common walkways and exits.

Description of Violation

On 11/6/23 at 10:58 AM, there were 2 cushions present on a chair in the home's designated smoking section.

Plan of Correction

Directed (████ - 12/15/2023)

The two cushions were removed immediately after the inspector informed us of the hazard on 11/6/2023. I had a re-education with the maintenance director on 11/17/2023. The daily checks were implemented on the same day as the re-education on 11/17/2023. The checks will be conducted by maintenance director █████ checks resident and common bathroom fans, resident and common bathroom water temperatures not reaching 120 degrees Fahrenheit, checking for flammable objects in the smoking designated area, portable space heaters in the building, extension cords, and tears in window screens and reports any findings back to me. (DIRECTED: The checks conducted by the maintenance director shall begin on 12/18/23 and be conducted daily for 1 month then weekly thereafter to ensure the designated smoking area is a safe distance from heat sources, hot water heaters, combustible or flammable materials, including cushions. █████ 12/15/23).

DIRECTED: By 12/30/23: All staff persons shall be reeducated on the home's smoking procedures, which includes ensuring the designated smoking area is a safe distance from heat sources, hot water heaters, combustible or flammable materials, including cushions. Documentation of the staff education shall be kept in accordance with 2600.65i. █████ 12/15/23

Proposed Overall Completion Date: 12/14/2023

Directed Completion Date: 12/30/2023

Implemented █████ - 01/03/2024)

181c - Self-administration Assessment

10. Requirements

2600.

181.c. The resident's assessment shall identify if the resident is able to self-administer medications as specified in § 2600.227(e) (relating to development of the support plan). A resident who desires to self-administer medications shall be assessed by a physician, physician's assistant or certified registered nurse practitioner regarding the ability to self-administer and the need for medication reminders.

Description of Violation

On 11/6/23, resident #1's hemorrhoid cream was present in resident #1's bedroom; however, resident #1's most recent medical evaluation, dated █████/23, indicates resident #1 cannot self-administer medications.

Plan of Correction

Accept (████ 12/15/2023)

The resident's cream was immediately removed from the room on 11/13/2023. On 12/1/2023 myself and █████ RN held a training for all nurses and med-techs about self-administration to ensure resident safety. Documentation of the education will be kept in accordance with 2600.65i. To monitor the violation, starting on 12/1/2023 I have my resident care coordinator and LPN, █████ █████ complete weekly rounds to each resident room that cannot self-administer and search to make sure they don't have any medications or creams.

181c - Self-administration Assessment (continued)

Licensee's Proposed Overall Completion Date: 12/14/2023

Implemented () - 01/03/2024)

187b - Date/Time of Medication Admin.

11. Requirements

2600.

187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Staff person C routinely prepares medications in labeled cups for numerous residents at one time. Staff person C then administers the medication cups to each resident on one side of the hallway at a time, then returns to the medication room and documents the medication administration on each resident's medication administration record (MAR).

Plan of Correction

Accept () - 12/15/2023)

() RN and I held a training regarding the medication procedure and the correct way to document medications for each resident on 12/1/2023. Documentation of the education will be kept in accordance with 2600.65i. Staff person C did in fact receive the training as shown in the sign-in in the attachment. (), my resident care coordinator, implemented routine med-pass checks on 12/4/2023 to ensure compliance. These are done randomly once every day, with the exception of the midnight med-pass being checked on once a week. This is to ensure the nurses and med-techs are following the correct administration/documentation procedures to ensure resident safety during med pass. Documentation of the education will be kept in accordance with 2600.65i.

Licensee's Proposed Overall Completion Date: 12/14/2023

Implemented () - 01/03/2024)

225c - Additional Assessment

12. Requirements

2600.

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

- 1. Annually.

Description of Violation

Resident #3's most recent assessment was completed on ()/23; however, resident #3's previous assessment was completed on ()/22.

Plan of Correction

Accept () - 12/15/2023)

I have created a spreadsheet with resident DME and RASP dates from time of initial, annual, and significant change assessments on 12/6/2023. () my resident care coordinator, has been in charge of reviewing the spreadsheet at the beginning of every month starting on 12/6/2023. () is to review the spreadsheet by the first of every month to ensure compliance with resident records and 2600.225.c.

Licensee's Proposed Overall Completion Date: 12/14/2023

Implemented () - 01/04/2024)