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

November 30, 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

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 10/04/2023, 10/05/2023 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* **License #**: *42645* **License Expiration**: *11/10/2023*

Address: *100 HIGH POINT DRIVE, KANE, PA 16735*

County: *MCKEAN* **Region**: *WESTERN*

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**: *L&I*

Type: *I-2* **Date**: *11/10/2010* **Issued By**: *Kane Borough*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *22* **Waking Staff**: *17*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *10/05/2023*

Inspection Dates and Department Representative

10/04/2023 - On-Site: [redacted]

10/05/2023 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *33* **Residents Served**: *22*

Secured Dementia Care Unit

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

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: [redacted] **Are 60 Years of Age or Older**: *21*

Diagnosed with Mental Illness: [redacted] **Diagnosed with Intellectual Disability**: [redacted]

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

10/04/2023 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/22/2023*

Inspections / Reviews *(continued)*

10/23/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2023*

Reviewer: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *10/25/2023*

10/30/2023 - POC Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2023*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *11/27/2023*

11/30/2023 - Document Submission

Submitted By: [redacted] **Date Submitted:** *11/22/2023*

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

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standard Act, enacted 6/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil-fuel burning device or appliance. On 10/4/23, the carbon monoxide alarm was approximately 6 feet from the 2 gas hot water tanks/boilers in the 99 Boiler Room in the entrance/common area of personal care and skilled nursing.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

The carbon monoxide alarm in question is hardwired directly into the smart system . The system was installed by Simplex and is inspected and tested every 6 months by either them or our maintenance department. All smoke detectors, carbon monoxide detectors, and alert panels are tested for function within the system. The system and all components pass all federal, state and local laws, ordinances and regulations as well as every Department of Health and Life Safety Survey since installation in 2016-2017. Personal Care has no fossil fuel burning devices or appliances. The carbon monoxide alarm and boiler in question is housed in the nursing home. This is not a shared common area as stated. Personal Care residents are welcome visitors to the nursing home. However in order to also be in compliance with 2600 regulations a carbon monoxide alarm has been purchased. The alarm will be located outside the boiler room in the location suggested by DHS personnel and is scheduled to be installed by facility maintenance personnel on 10/26/23. Facility maintenance personnel will inspect, test for function and change the batteries in the device every 6 months.

Licensee's Proposed Overall Completion Date: *11/01/2023*

Implemented [redacted] - 11/30/2023)

64a - Admin Training

2. Requirements

2600.
64.a. Prior to initial employment as an administrator, a candidate shall successfully complete the following:
1. An orientation program approved and administered by the Department.

Description of Violation

Staff person A, who is the [redacted], has not successfully completed an orientation program approved and administered by the Department.

Plan of Correction ***Accept [redacted] - 10/23/2023)***

Staff person A successfully did attend the orientation program in 2017 while completing the 100 hour administrator course at Penn State Dubois however does not have a certificate to prove compliance. [redacted] has enrolled in an orientation program scheduled on October 27, 2023 to be in compliance with regulation 64a. Following completion of program several copies of certificate will be made and one will be placed in personnel file along with 100 hour completion certificate and test completion certificate to be easily accessible for future inspections. HR has a list of required qualifications and documentation that must be present for employing Personal Care staff. The orientation certificate has been added to PCHA's list of required documents necessary to be in personnel files. It will be the potential employee's responsibility to provide needed documents prior to employment as HR keeps strict records and an oversight will not occur again.

Licensee's Proposed Overall Completion Date: *11/15/2023*

64a - Admin Training *(continued)*

Implemented [redacted] - 11/30/2023)

65f - Training Topics

3. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
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 persons B and C did not receive training in care for residents with mental illness or an intellectual disability during training year 8/1/22-7/31/23.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

A training plan for the training year 8/1/22-7/31/23 was developed by the PCHA to include Care for residents with mental illness or mental retardation, or both, if the population is served in the home. PCHA led the training that was held on 6/29/23 with staff. The training focused on caring for residents that are "older, people with physical, behavioral health or cognitive disabilities". When staff are unable to attend a training on the day it is scheduled THE PCHA or designee will meet with that staff member on their next scheduled workday to assure they receive necessary training and complete sign in sheet. The staff training plan for 8/1/23-7/31/24 was developed to include Care for residents with mental illness or mental retardation, or both, if the population is served in the home. A training is scheduled for October 25, 2023 by facility staff behavior health specialist focusing on caring for residents w/ mental health and ID or both. PCHA or designee to assure all staff attend training when scheduled a sign in sheet to be provided. The training will be recorded for staff to watch on their next scheduled day to work if they are not in attendance. Any casual employee will be required to complete the training on their next scheduled workday. PCHA or designee will keep sign in sheet along with announcement of training in a folder for all annual completed training. The sign in sheet will also be scanned in as a computer document for the next year's review. Moving forward all sign in sheets for training will be kept in a folder specifically for training as well as a computer document for all sign in sheets to be scanned into. A spreadsheet is already in place with the names of staff and the date each training was completed. The spreadsheet has all the mandatory trainings as well as any additional trainings that occur throughout the year.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 11/30/2023)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

On 10/4/23, at approximately 11:30 am., there was an unlabeled bar of soap in the shared bathroom in bedroom [redacted]. There were also multiple plastic cups with unknown stains in the wall cupboard directly next to the bathroom door.

85a - Sanitary Conditions *(continued)*

Plan of Correction ***Accept (- 10/30/2023)***

Resident 3 washed hands leaving the bottom half of his soap container containing the bar sitting on shared bathroom sink. The other wall cupboard mentioned belongs to the vacant bed in the room and the roommate had taken over the cabinet as well as own which staff was unaware of. The known substance was mouthwash as there was also a near empty mouthwash bottle within the space labeled with the name. The resident's name was written on the bottom half of the soap dish and returned to inside the resident cabinet by the PCHA, the intended vacant cabinet was cleaned out by the RA on duty at that time, both residents were educated regarding the reasons for staff touching their personal belongings by the PCHA. A portion has been added to the monthly resident council meetings, to be presented by PCHA or designated person, regarding 102i, no shared bar soap, dishes must be labeled both top and bottom and best practice will be to put them back in their designated cupboards after use. All residents will also be reminded to throw away the plastic cups after use for infection control purposes and to avoid using furniture and storage areas not assigned to them. Residential Aides are in and out of bathrooms for the purpose of passing linens and housekeeping at least twice daily and are responsible to monitor for shared items or items in need of disposal. PCHAs or Nurse manager will conduct random spot checks of bathrooms for regulatory compliance for weekly for 4 weeks. Soap dishes have been added to the quarterly QA (assigned to a Residential Aide) of resident items to assure are labeled.

Licensee's Proposed Overall Completion Date: *11/18/2023*

Implemented - 11/30/2023)

132h - Designated Meeting Place

5. Requirements

2600.
132.h. Residents shall evacuate to a designated meeting place away from the building or within the fire-safe area during each fire drill.

Description of Violation

During the fire drill on 2/27/23, at and 8/29/23, at ., not all residents evacuated to a designated meeting place away from the building or within the fire-safe area.

* *2/27/23 - 20 residents, 19 evacuated*
* *9/29/23 - 24 residents, 23 evacuated*

Plan of Correction ***Accept - 10/30/2023)***

Resident #3 refused to evacuate during the February 27, 2023 drill. The regulation and vital importance of fire drills are discuss at length upon admission. All residents and their designated person sign a separate agreement/understanding regarding progressive steps leading up to possible discharge from the facility for lack of participation. Resident was spoken to on 2/27 by PCHA regarding the regulation, safety of self and others and reminded of the agreement that signed in regards to this being first warning. An unannounced drill was again held and all residents successfully participated and evacuated the next night 2/28/23. The designee leading resident council each month has always provided reminders and education about monthly fire drills, being prepared, where our meeting area is and that it is mandatory to participate and evacuate. This practice will continue. PCHA or designee will continue to educate and receive signatures upon admission regarding fire drills specific to our home, counsel and follow the progressive steps as necessary for noncompliance of home rules and regulations.

Licensee's Proposed Overall Completion Date: *12/07/2023*

Implemented - 11/30/2023)

184a - Resident's Meds Labeled

6. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

Description of Violation

Resident #1 is prescribed, [redacted] daily. The pharmacy label indicates [redacted] needed.

Resident #2 is prescribed, [redacted] as needed. The pharmacy label indicates [redacted] daily.

Resident #3 is prescribed, [redacted] as needed. The pharmacy label states [redacted]

Repeat Violation: 9/27/22

Plan of Correction ***Accept [redacted] - 10/23/2023)***

All three mentioned medications are "staff to reorder "meaning they don't automatically arrive with exchange. Resident #1 is ordered Docusate both routine and prn and both of these instructions are accurate as per [redacted] orders. [redacted] routine card of [redacted] daily had been ordered however the prn card was filled and sent. Pharmacy was called by staff, alert stickers were put on the card acknowledging a difference in dose/strength and meanwhile was necessary to use it for the routine administration while awaiting another routine card to arrive. Resident #2 originally was ordered [redacted] routinely which was later changed to prn. Staff followed through, placed alert stickers on the card acknowledging the change in instruction and carried the order as needed. Upon receipt of a new card of [redacted] the label is anticipated to match and alert stickers will be unnecessary. Resident #3 had consistently refused the routine [redacted] therefore staff contacted the provider and requested it be changed to prn. The staff member receiving the prn order on 6/23 sent it to the pharmacy, checked and approved the new order on the QMAR but failed to follow up with alert stickers on the medication package as required to therefore not acknowledge the change in directions. An education is being planned and all staff is being reeducated on proper med pass with a focus on comparing labels to the QMAR with every administration and receiving new orders/changes in orders and what to do from start to finish. Proper med pass review education is conducted annually by PCHA who is also one of the medication administration trainers and will continue along with these more targeted educations. Audits will be conducted once a week for 6 weeks to ensure compliance of medication and label changes to assure matching labels with QMAR or the presence of alert stickers. After the initial 6 weeks of audits, monthly audits will be conducted for 6 months by Nurse manager, PCHA or designee assigned.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 11/30/2023)

187b - Date/Time of Medication Admin.

7. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

187b - Date/Time of Medication Admin. *(continued)*

Description of Violation

Resident #3 is prescribed, [redacted] a day and [redacted] daily. Resident #1's September 2023 medication administration record (MAR), does not include the initials of the staff person who administered them on 9/3/23 at [redacted]

Resident #2 is prescribed, [redacted] as needed. Resident #2's September 2023 MAR indicates on 9/11/23, at [redacted]. an aide administered/injected the medicatio. However, it was the home's nurse that administered the medication on 9/11/23, at [redacted]

Repeat Violation: 9/27/22

Plan of Correction ***Accept [redacted] - 10/23/2023)***

Resident #1 went out of facility for a holiday gathering, staff on duty neglected to document anything in the MAR for the absence but did sign the narcotic ledger and document the absence elsewhere as the medication was sent with the resident and all counts were correct. Resident #2 required an IM injection which requires a nurse to administer. The staff LPN did administer the injection and signed the narcotic ledger, the RA was instructed to note that the shot was given by the nurse but neglected to do so on the QMAR and initialed the administration as normal without additional notation there. The RA did however also document in the nurse's notes in detail that the shot was administered, what time and by who. There has since been an addendum added on the QMAR dated 10/5 additional information stating that the injection was administered by the facility LPN. This topic has been added to the agenda of the education for 84a. Proper med pass review education is conducted annually by PCHA who is also one of the medication administration trainers and will continue. A personal shift audit is being created and every individual passing medication will be responsible to run a report and sign off at the end of their shift indefinitely that their MAR is complete and accurate with no incomplete spaces. A weekly report will be run to assure no missing spaces on the QMAR by the nurse manager or designee for 6 weeks and then the report will be done monthly thereafter. Progressive disciplinary action will be taken for inaccurate or repeated incidents. A medication administration course will also be held for staff person/persons in need of remediation regarding errors leading to said violations related to medications in this report. PCHA Trainer will administer the course.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented ([redacted] - 11/30/2023)

225a - Assessment 15 Days

8. Requirements

2600.
225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

Resident #4 admitted into the home on [redacted]. On [redacted], resident #4 had an enabler bar on the bed. However, on [redacted] resident #4's RASP, dated [redacted] did not address the use/need of the enabler bar.

Plan of Correction ***Accept ([redacted] - 10/23/2023)***

There was no mention of an enabler bar on the initial assessment for resident #4 because the individual doing the

225a - Assessment 15 Days (continued)

RASP was unaware of it being on the bed. Resident #4 was not to have an enabler bar therefore it would not be addressed. The bar had been left over on the bed from the last individual that had used that bed. Upon the inspector walking through doing the physical inspection, she mentioned in casual conversation about an enabler. The PCHA, knowing that the resident "doesn't have one" immediately called maintenance to have it removed. Inspector was aware that the enabler was immediately removed on [redacted]. Audit and checklist put in place to inspect room prior to any admission as there may be no assistive device without an order, education regarding risks and benefits and must always be addressed on the individuals assessment and support plan. Residential Aide, upon applying linens to the bed and cleaning/tidying the room in anticipation of a new admission will sign off that the bed doesn't contain an enabler. If an enabler is found, maintenance will be notified and will be removed until ordered. Residential Aide will report all findings and turn their audits into PCHAs or nurse manager for all admissions occurring for 3 months.

Licensee's Proposed Overall Completion Date: *12/01/2023*

Implemented [redacted] - 11/30/2023)

227d - Support Plan Medical/Dental

10. 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

On [redacted], resident #3's support plan, dated [redacted], did not document the resident's refusal to participate in fire drills and how this need will be met.

Plan of Correction ***Accept [redacted] - 10/30/2023)***

After Resident #3 refused to evacuate during the February 27 drill he was spoken to by PCHA regarding the regulation, safety of self and others and [redacted] decision making behaviors. [redacted] was reminded of the fire drill evacuation agreement that [redacted] signed and informed this serves as first warning. [redacted] had been evacuated leading up to that day and following the talk with PCHA on 2/27 has been compliant with the fire drills. A one time ever refusal (1 of 15 drills since living here) would not have made the nurse manager highlight fire drill safety as a concerning behavior. At the time of the completion of the RASP 4/12/23 resident #3 had no significant behaviors. However 5/30/23 the resident does tend to begin to question and challenge any and all rules or regulations for their validity. [redacted] made questionable decisions related to health, well being and safety. At the time that [redacted] behaviors did become a concern no direct care staff updated the 4/12/23 RASP to indicate the challenges. The resident was agreeable to see a psychiatrist and had a first visit on [redacted]. PCHA and Nurse manager added written updates/addendum to attach to [redacted] RASP related to [redacted] behaviors, decisions, choices [redacted] makes and confusion dated 10/21/23. The nurse manager or designee is primarily responsible for the initial RASPs and all direct care staff are responsible for updates added throughout the year. Audits will be conducted once a week by the Nurse Manager or designee for 6 weeks to ensure compliance of new/changed orders or conditions are reflected on the RASP as necessary. After the initial 6 weeks of audits, monthly audits will be conducted for 6 months by Nurse manager, PCHA or designee assigned

Licensee's Proposed Overall Completion Date: *10/25/2023*

Implemented [redacted] - 11/30/2023)