pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **LUTHER RIDGE FACILITY OPERATIONS LLC**
LEGAL ENTITY

To operate **LUTHER RIDGE AT SEIDERS HILL**
NAME OF FACILITY OR AGENCY

Located at **160 RED HORSE ROAD POTTSVILLE, PA 17901**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Assisted Living**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **135**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

PROVISIONAL

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2800: Assisted Living Residences
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **April 19, 2024** until **October 19, 2024**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **224662**

ISSUING OFFICER

ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628P – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Sent via email [redacted]
CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: APRIL 19, 2024

[redacted]
Luther Ridge Facility Operations, LLC
160 Red Horse Road
Pottsville, Pennsylvania 17901

RE: Luther Ridge at Seiders Hill
License: 224662

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, Office of Long-Term Living licensing inspections on January 18, 2024, February 8, 2024, February 21, 2024, and February 22, 2024, of the above facility, the violations specified on the enclosed Licensing Inspection Summaries (LISs) were found.

Based on violations with 55 Pa. Code Ch. 2800 (relating to Assisted Living Residence), the Department hereby REVOKES your certificate of compliance (license number 224661) dated October 17, 2023, to April 17, 2024, and issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. The license dated October 17, 2023, to April 17, 2024, is NOT reinstated upon expiration of this SECOND PROVISIONAL license. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) and 55 Pa. Code § 20.71(a)(2); (3); (4); (5); (6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from April 19, 2024 to October 19, 2024.

All violations specified on the LISs must be corrected by the dates specified on the report and continued compliance with 55 pa. Code Ch. 2800 (relating to Assisted Living Residence), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2800 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 or 2800 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
65a	III	76	$3	$228	15 calendar days from mailing date of this letter
65e	III	76	$3	$228	15 calendar days from mailing date of this letter
65i	II	76	$5	$380	5 calendar days from mailing date of this letter
141b	III	76	$3	$228	15 calendar days from mailing date of this letter
132d	II	76	$5	$380	5 calendar days from mailing date of this letter
187d	II	76	$5	$380	5 calendar days from mailing date of this letter
225a	II	76	$5	$380	5 calendar days from mailing date of this letter
227d	III	76	$3	$228	15 calendar days from mailing date of this letter

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35. If you decide to appeal your PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

[redacted]
Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building
625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summaries

cc: [redacted]

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *04/17/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *PA Dept. L&I*

Staffing Hours

Resident Support Staff: *1* **Total Daily Staff:** *99* **Waking Staff:** *74*

Inspection Information

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

Reason: *Complaint, Provisional, Interim* **Exit Conference Date:** *02/22/2024*

Inspection Dates and Department Representative

02/21/2024 - On-Site: [redacted]

02/22/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *76*

Special 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:** *75*

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

Have Mobility Need: *22* **Have Physical Disability:** *0*

Inspections / Reviews

02/21/2024 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/17/2024*

03/20/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/26/2024*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2024*

03/26/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *03/26/2024*

Reviewer: [redacted] **Follow-Up Type**: *Bypass Document Submission*

03/26/2024 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted**: *03/26/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence 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 assisted living residence.

Description of Violation

The residence does not have the Licensing Inspection Summary dated 8/23/23 posted.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

Immediate Action: The Public Version of 8/23/23 LIS was printed and immediately posted on the board dedicated to our current license, a copy of the 2800 regulations, and the LIS' for the past 12 months.
The plan is the Administrator will immediately print the public version of the LIS and immediately post same.
A previous violation and plan of correction is the verification of all pertinent items are posted on the board dedicated to the items in a conspicuous and public place, every Friday the Administrator reviews the board and signs that the board is accurate and up to date. That plan will continue for this violation as well, inclusive for all items to be displayed in the public conspicuous dedicated place. Corporate RN will oversee the Administrator ongoing and continuous for accuracy.
The Administrator will monitor ongoing and continuous compliance is maintained at our Quality Management meeting monthly on the 18th of every month. Any changes will be made at The Quality Management Meeting monthly ongoing and continuous.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented [redacted] - 03/26/2024)

18 Other laws, regs, ordins.

2. Requirements

2800.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

It was noted during a review of Policies and Procedures, that the Residence has not developed a policy outlining the use of voice-controlled devices by the facility and their residents.

Plan of Correction ***Accept [redacted] 03/20/2024)***

Immediate Action: A policy and procedure was developed outlining the use of voice-controlled devices by the facility and our Residents.
** Luther Ridge does not allow the use of voice-controlled devices by the facility and our Residents.*
Director of Activities informed all current Residents, and Administrator informed all staff that voice-controlled devices are not permitted at Luther Ridge.
Admissions will inform all new Residents' during the admission process and at the time of admission of our policy and procedure ongoing and continuous.
All nursing staff will monitor daily during rounds and The Director of Wellness will monitor monthly for compliance ongoing and continuous. The Corporate RN will provide oversight for continued compliance ongoing.
The Administrator will oversee ongoing and continuous compliance is maintained at our monthly Quality Management Meeting on the 18th of every month and will be discussed and addressed and reviewed monthly at

18 Other laws, regs, ordins. (continued)

this time.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented [redacted] - 03/26/2024)

22a1 Medical Eval - time frames

3. Requirements

2800.
22.a. Documentation. The following admission documents shall be completed for each resident:
1. Medical evaluation completed within 60 days prior to admission on a form specified by the Department. The medical evaluation may be completed within 15 days after admission if one of the following conditions applies

Description of Violation

Resident #2 was admitted to the residence on [redacted]-2023 directly from [redacted] home with no home health care services. The Document of Medical Evaluation (ADME) was completed on 8-1-23, exceeding the 15-day grace period after admission.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Resident #2's ADME was reviewed with POC notation that the time frame exceeded the 15 day grace period after admission.
All Resident ADME's were audited for compliance.
Wellness Secretary was re-educated on this regulation as well as the Director of Wellness.
The Director of Wellness will oversee the Wellness Secretary and verify all ADME's are accurately completed ongoing and continuous. The Administrator will oversee the Wellness Director ongoing and continuous.
The Administrator will oversee the Director of Wellness for verification of accuracy of all ADMEs at the time of completion ongoing and continuous.
The Administrator will monitor ongoing and continuous this regulation is adhered to and compliance is maintained.
Corporate Consulate RN will oversee the Administrator ongoing and continuous. The ADME's will be reviewed monthly on the 18th of every month at The Quality Management Meeting, and all changes will be corrected monthly at this time.

_____

ADME's were audited and completed on 3-8-24
The Education was completed on 3-7-24

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

26b Quality management plan content

4. Requirements

2800.
26.b. The quality management plan shall address the periodic review and evaluation of the following:

Description of Violation

The Quality Management plans dated 12/2023 and 1/2024 were reviewed. These plans do not include the required elements of, complaint procedure, staff person training, Licensing Violations, or Resident or family councils.

26b Quality management plan content *(continued)*

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Quality Management Plans for 12/23 and 1/24 were updated to include: Complaint Procedure, Staff person training, Licensing Violations, and Resident Council. The Community does not have a Family Council. The Wellness Director and The Wellness Secretary were re-educated on this regulation. The Wellness Secretary and The Wellness Director will formulate The Quality Management and attendees will participate monthly to verify compliance.
The Administrator will oversee the Wellness Director and The Wellness Secretary monthly ongoing and continuous. Consulate Corporate RN will oversee the Administrator ongoing and continuous. Verification of all required elements will occur monthly at The Quality Management Meeting any additions or changes will be made at this time, this will occur monthly continually.

_____

The Quality Management Plan was updated 3-7-2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

51 Criminal background checks

5. Requirements

2800.
51. Criminal background checks

Description of Violation

Staff persons "A" [redacted] 13), "B" [redacted] /22), and "C" [redacted] /21) did not have a Criminal History Check in their employee records.

Plan of Correction ***Accept [redacted] 03/26/2024)***

Immediate Action: Staff Persons: A and C criminal background checks were run with no issues. Copy was placed in their employee files.
Staff Person B is no longer an employee.
An employee file audit was conducted on all current employees.
Verification of all Criminal Background checks was conducted.
Plan: All new employees must apply online, accept an offer letter, and begin their online onboarding, an offer is contingent on background check clearances.
The Business Office Manager is no longer employed.
The Administrator will submit all new hire information to corporate to process and the policy will be followed for all new hires as outlined above in the absence of the onsite Business Office Manager. Corporate Human Resources will provide oversight continually and ongoing.
The Administrator will monitor for compliance ongoing and continuous monthly at The Quality Management meeting on the 18th of every month.

_____

Staff member A was submitted 3/6/24 and received clear on 3-8-2024, Staff member C was submitted 3-7-2024 and received clear on 3-15-2024
The audit was completed by March 8, 2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

51 Criminal background checks *(continued)*

Not Implemented [redacted] - 03/26/2024)

65a Fire Safety-1st day

6. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

Description of Violation

Staff person D, hired [redacted]/23, did not have an orientation prior to their first day of work in general fire safety and emergency preparedness and the 7 required topics outlined under this regulation.
Repeat Violation - 3-9-2023, et al, 7-20-2023.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Staff Person D was immediately trained on general fire safety and emergency preparedness and the seven required topics highlighted as evacuation, staff duties and responsibilities during fire drills, the designated meeting place, smoking safety procedures, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services.
An employee audit of all files was conducted to verify compliance and corrections were made.
The Business Office Manager is no longer an employee.
The Administrator will conduct the new hire trainings and orientations until a new Business Office Manager is in place. The Administrator will oversee this is completed ongoing and continuous at the time of a new hire and ongoing and continuous once a new Business Office Manager is hired. Consulate Human Resources will oversee this regulation is maintained ongoing and continually. The Quality Management Meeting on the 18th of every month will review and audit for accuracy.

_____
Staff Person D was trained on [redacted]-24
Audits were completed by March 15, 2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

65e Rights/Abuse 40 Hours

7. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person D, hired [redacted]/23, did not have orientation training within their first 40 scheduled working hours that included the following required topics:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act
(4) Reporting of reportable incidents and conditions.
(5) Safe management techniques.

65e Rights/Abuse 40 Hours (continued)

(6) Core competency training that includes the following:
i. Person-centered care.
ii. Communication, problem solving and relationship skills.
Repeat Violation - 3-9-2023, et al, 7-20-2023.

Plan of Correction ***Accept[redacted] 03/26/2024)***

Immediate Action: Staff Person D received their training for their first 40 scheduled working hours that was missed.
All employee files were audited for compliance and missed trainings were corrected for plan of correction.
The Business Office Manager is no longer employed.
In the absence of The Business Office Manager, the Administrator will conduct all new hire orientations and trainings through our corporate recruiter and corporate Human Resources onboarding, with comprehensive backgrounds run through EDGE, which includes PATCH, but not limited to.
The Administrator will oversee and verify compliance ongoing and continuous. Corporate Human Resources will oversee this regulation is completed for accuracy. Orientations and the necessary components will be reviewed monthly at The Quality Management meeting on the 18th of every month and any corrections will be made at this time

_____

Staff Person D was trained [redacted]-24
Audits were completed 3-15-24

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented[redacted] - 03/26/2024)

65f Ancillary staff orientation

8. Requirements

2800.
65.f. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Prior to their 1st day of work, Ancillary Staff person D, hired [redacted]/23, did not have an orientation for the specific duties outlined in the position they were hired for.

Plan of Correction ***Accept[redacted] - 03/26/2024)***

Immediate Action: Staff Person D was oriented to their specific job function for the POC.
Employee File Audit was conducted on all employee files to verify compliance, Corrections were made to existing active employees for this Plan of Correction.
The Business Office Manager is no longer employed.
The Administrator will conduct all on site new hire orientations and trainings in the absence of The Business Office Manager.
The Administrator will monitor ongoing and continuous for compliance and completion, in the absence of The Business Office Manager and will oversee once a Business Office Manager is hired. Corporate Human Resources will oversee The Administrator for compliance ongoing and continually. This will be audited and reviewed monthly at the Quality Management Meeting on the 18th of every month and any corrections will be made at this time.

_____

65f Ancillary staff orientation (continued)

[redacted]*2024 Staff person D was trained for POC*
Audits were completed March 15, 2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

65g Initial direct care training

9. Requirements

2800.
65.g. Direct care staff persons may not provide unsupervised assisted living services until completion of 18 hours of training in the following areas:

Description of Violation

Staff person B's employee file did not contain the "Certificate of Completion" from the Department to indicate they completed the required 18 hrs. of online Direct Care training and passed the course.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Staff Person B is no longer an employee.
An audit was conducted of all Medication Technicians and Resident Aides for Initial direct care training for 18 hours of training.
Corrections were made for all Medication Technicians and Resident Aides.
Verification of all Certificates of completion was conducted and filed.
The Business Office Manager and onsite Human Resources coordinator is no longer an employee.
The new process for all new hires is the Administrator in the absence of Business Office Manager and Human Resources will direct the training and verify completion prior to the nursing department staff providing unsupervised assisted living services. Corporate Human Resources will oversee the Administrator ongoing and continually. This will be audited and reviewed monthly on the 18th at the Quality Management Meeting for recommendations and results at the time of the meetings.

_____
Audits were completed March 15, 2024

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented ([redacted] - 03/26/2024)

65i Training topics

10. Requirements

2800.
65.i. Training topics for the annual training for direct care staff persons shall include the following:

Description of Violation

Direct Care Staff Persons A (hired [redacted]/13), B (hired [redacted]/22), and C (hired [redacted]21) were not trained in 2023 in the following required annual training topics: (1)Medication self-administration training; (2)Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and

65i Training topics (continued)

support plan; (3)Care for residents with dementia, cognitive and neurological impairments; (4)Infection control and general principles of cleanliness and hygiene and areas associated with immobility, such as prevention of decubitus ulcers, incontinence, malnutrition and dehydration; (5) Assisted living service needs of the resident; (6) Safe management techniques; (7) Care for residents with mental illness or an intellectual disability, or both, if the population is served in the residence.
Repeat Violation - 3-9-2023, et al, 7-20-2023.

Plan of Correction ***Accept (- 03/26/2024)***

Immediate Action: Educated and re-trained all direct care staff persons on this regulation and the necessity of completing all required annual training and printing their certificates if online and attending in person if set up as in person training.
The annual training was presented to all staff, all signed the annual training calendar.
The Wellness Director was trained on assigning Relias trainings and setting up in person training classes on site for 2024.
The Administrator will oversee the Wellness Director ongoing and continuous.
The Corporate RN will oversee the Administrator ongoing and continuous. This will be reviewed at The Monthly Quality Management Meeting that all trainings are being completed according to the calendar set for trainings, the Administrator will ensure completion and staff would print their certificates if Relias based training and copies of sign in sheets will be added to each employee's file.

_____
All staff was trained on 2/29/24
Audits were completed by 3/15/24

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented - 03/26/2024)

85e Trash outside

11. Requirements

2800.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

One of the Residence's 2 dumpsters was overflowing with empty cardboard boxes and the other had a lid that was bent causing an opening which allowed access to insects and animals.

Plan of Correction ***Accept - 03/20/2024)***

Immediate Action:
The cardboard boxes were flattened, and a re-education and training was provided to housekeeping, maintenance and kitchen. We contacted our vendor to assess the bent lid. Housekeeping, maintenance, and kitchen were re-educated to daily assess that the dumpsters are closed at all times and in good condition. The bent lid cannot be fixed, and a replacement dumpster was provided.

Maintenance is rounding daily and verifying the dumpsters lids are closed.

85e Trash outside (continued)

The Administrator will oversee the ancillary departments who are accessing the dumpsters.
Consulate Corporate and Healthcare Services Group (outsourcing company for kitchen and housekeeping will have oversight to their respective departments). This will be reviewed monthly at The Quality Management Meeting on the 18th of every month for daily compliance.

.

Licensee's Proposed Overall Completion Date: *03/15/2024*

Not Implemented [redacted] - 03/26/2024)

95 Furniture & Equipment

12. Requirements

2800.
95. Furniture and Equipment - Furniture and equipment must be in good repair, clean and free of hazards.

Description of Violation

The 3rd floor (top floor) exit doors to the stairwells have a magnetic door alert in addition to the roam alert system, that is louder and can be heard throughout the 3rd floor. The west stairwell exit door alert system was not working during the initial walkthrough of the building due to the magnetic box being removed from the exit door and from the worker's station.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: The magnetic box was replaced while inspectors were on site.
The Staff were re-educated and trained that the magnetic box is never to be removed.
The Maintenance Director and The Maintenance Assistant were re-educated and trained.
The Maintenance Director will ensure the magnetic boxes are intact daily during rounds of the community, in the absence of The Maintenace Director, The Maintenace Assistant will ensure the magnetic boxes are intact during daily rounds.
The Administrator will oversee the Maintenace Director and The Maintenance Assistant ongoing and continuous.
This will be reviewed monthly at The Quality Management meeting on the 18th of every month continually.

All staff were trained on 2/29/24
completed on 2/29/24

95 Furniture & Equipment *(continued)*

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

96b First aid kit- Location

13. Requirements

2800.
96.b. Staff persons shall know the location of the first aid kit.

Description of Violation

On the day of the inspection, Staff were unable to locate the First Aide Kit on the 3rd floor.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Staff were unable to locate the First Aide Kit because we only had one First Aid kit onsite. 10 First Aid kits were ordered March 5, 2024, to our vendor.
The Wellness Director educated and trained all staff of the locations where they will locate a first aid kit once our order arrives.
The Wellness Secretary and The Wellness Director will audit the locations monthly.
The Administrator will oversee The Wellness Director ongoing and continuous. The Quality Management Meeting will ensure this regulation is followed and any corrections will be made on the 18th of every month
----
All staff were trained 3/8/24
First Aid kits arrived 3/20/24 and fixed same date

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

100b Removal snow/obstructions

14. Requirements

2800.
100.b. The home shall ensure that ice, snow and obstructions are removed from outside walkways, ramps, steps, recreational areas and exterior fire escapes.

Description of Violation

The west exit on the lower level of the building has an exit door with a ramp to the gazebo. The ramp walkway to the gazebo is snow covered and has not been shoveled or plowed. To allow for safe evacuation in the case of an emergency, this walkway would not be able to be utilized safely.

Plan of Correction ***Accept [redacted] 03/20/2024)***

Immediate Action: The Maintenace Assistant removed the snow blocking the egress while inspectors were on site. Administrator re-educated the Director of Maintenace and The Maintenace Assistant that all egress' are to be clear from any obstructions at all times.
Plan: The Maintenace Director will walk the Community daily at the beginning of shift to verify all egress' are clear of any obstructions. In the absence of The Maintenance Director the Maintenance Assistant will conduct the daily rounds to verify all egress' are free of obstruction.
The Administrator will oversee the Director of Maintenace and The Maintenace Assistant ongoing and continuous

100b Removal snow/obstructions (continued)

for compliance. Corporate Consulate Facilities Director will oversee the Administrator ongoing and continuous. This regulation will be reviewed ongoing and continually at The Quality Management Meeting on the 18th of every month.

Licensee's Proposed Overall Completion Date: *03/11/2024*

Not Implemented [redacted] 03/26/2024)

105g Dryer lint removal

15. Requirements

2800.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

During the initial walk through, Department Rep. noted and accumulation of lint in the lint trap of the industrial dryer on the ground floor.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: The lint from the industrial dryer on the ground floor was immediately removed.
All Nursing Staff were re-educated on the necessity and compliance of this regulation.
The Maintenace Director was re-educated to oversee the Nursing staff and the Dryer lint removal. The Maintenace Director re-educated the Maintenace Assistant to assure all dryers are free of lint per manufacturer's instructions.
The Maintenace Director will verify daily there is no lint in the dryers. In The absence of The Maintenace Director, the Maintenance Assistant will oversee. The Administrator will oversee the Maintenance Director and the Maintenance Assistant ongoing and continuous. This regulation will be reviewed monthly at The Quality Management Meeting on the 18th of every month for compliance continually.
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lint was removed on 2/22/24
Training completed 3/11/24

Licensee's Proposed Overall Completion Date: *03/20/2024*

Not Implemented [redacted] - 03/26/2024)

121a Unobstructed egress

16. Requirements

2800.
121.a. Stairways, hallways, doorways, passageways and egress routes from living units and from the building must be unlocked and unobstructed.

Description of Violation

On the 3rd floor (top floor), the western stairwell there was an overturned walker, blanket, pillow, and slippers blocking the top of the stairwell. In an emergency evacuation, this would prevent immediate egress down the stairwell.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: the walker, blanket, pillow and slippers were immediately removed while the inspectors were onsite.

121a Unobstructed egress (continued)

The Administrator re-educated and trained The Maintenace Director and The Maintenace Assistant on this regulation.
The Maintenance Director will ensure all egress' are unlocked and unobstructed during daily morning rounds of the Community.
The Administrator will oversee the Maintenance Director and in the absence of The Maintenace Director the Maintenance Assistant ongoing and continuous. Review of this regulation will occur monthly at The Quality Management Meeting on the 18th of every month to ensure compliance.

_____
2-29-24 training was completed.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] 03/26/2024)

124 Notice to fire department

17. Requirements

2800.
124. The residence shall notify the local fire department in writing of the address of the residence, location of the living units and bedrooms and the assistance needed to evacuate in an emergency. Documentation of notification shall be kept.

Description of Violation

The Residence does not have a letter notifying the local fire department of the address of the facility, the location of the resident living units and bedrooms, and the type of assistance needed to evacuate the immobile residents in an emergency.

Plan of Correction ***Accept [redacted] - 03/20/2024)***

The Administrator notified the local fire department in writing of the address of the Residence, location of the living units and bedrooms, and the assistance needed to evacuate in an emergency.
Documentation of the notification is kept in the Survey Preparedness Binder on site.
The Administrator will ensure this is reviewed in the Quality Management Meeting monthly on the 18th of every month.
The Wellness Secretary prepared the Quality Management Plan to meet the requirements of the regulation.
The Wellness Director will review the Notice to The Fire Department monthly during the Quality Management Meeting monthly on the 18th of every month. The Administrator and The Director of Maintenace will note any changes and The Administrator will update the Fire Department as needed ongoing and continuous.
The Corporate Director of Facilities Management will oversee the Administrator. The Administrator will ensure this is reviewed monthly at The Quality Management Meeting on the 18th of every month to ensure accuracy of information is communicated to the fire department.

Licensee's Proposed Overall Completion Date: *03/14/2024*

Not Implemented [redacted] - 03/26/2024)

132c Fire drill records

18. Requirements

2800.

132c Fire drill records *(continued)*

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 residence 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

Based on an interview with Staff person "E" who conducted the last 3 fire drills at the Residence on 1/8/24,12/28/23, and 12/8/23, it was determined that they are including themselves in the number of staff participating in the drill and documenting it on the fire log.

The Residence's fire drill records for 1/8/24,12/28/23, and12/8/23 do not indicate the exits used for evacuation.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: The Maintenace Director and The Maintenance Assistant were re-educated and trained on this regulation that the persons conducting the drill cannot be included in the number of staff persons participating. The Administrator added the fire code record to the annual fire log binder, which encompasses the exits for evacuation. Fire Code Record is the new audit tool.

The Maintenance Director is responsible for compliance to this regulation, The Maintenance Assistant will be responsible in the absence of The Maintenance Director.

The Administrator will oversee The Maintenance Director and in the absence of the Maintenace Director the Administrator will oversee the Maintenance Assistant ongoing and continuous. A review of the fire drill records will occur at the monthly Quality Mangement Meeting on the 18th of every month.

2-23-24 training was completed

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

132d Evacuation

19. Requirements

2800.

132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the residence.

Description of Violation

The Residence's evacuation time determined by the fire safety inspector on 11/15/23 is 7 minutes. According to the Residence's fire drill records, a drill was conducted on 11/18/23 at 3:30pm, with an evacuation time of 10 minutes.

Repeat Violation - 3-9-2023, et al.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: The Maintenace Director and The Maintenace Assistant were re-educated and trained on the evacuation time by the fire safety inspector of 7 minutes.

All staff were educated and trained on the evacuation time of 7 minutes.

The Maintenance Director will conduct the evacuation drills and in the absence of The Maintenance Director the Maintenance Assistant will conduct the evacuation drills.

The Administrator will oversee the Maintenance Director and The Maintenace Assistant ongoing and continuous.

The Corporate Director of Facilities Management will oversee the Administrator ongoing and continuous. The Quality Management meeting will review monthly this regulation for compliance continually.

132d Evacuation (continued)

3-12-24 training was completed

.

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

141b1 Annual medical evaluation

20. Requirements

2800.
141.b. A resident shall have a medical evaluation:
1. At least annually.

Description of Violation

Resident #'s last two Documented Medication Evaluations (ADME) are dated 5-28-22 and then 7-9-23, exceeding the annual requirement.
Repeat Violation - 8-23-2023.

Plan of Correction ***Accept [redacted] 03/26/2024)***

Immediate Action: ADME's were audited, and corrections made for all Residents.
The Wellness Secretary created an audit form to tract annual due dates for all ADME's for our current Residents and will adjust as necessary to add all new Resident admissions. The Wellness Secretary will complete all ADME's with The Wellness Director. The Wellness Director will oversee The Wellness Secretary for accuracy ongoing and continuous. The Administrator will oversee The Wellness Director ongoing and continuous. The Corporate RN will oversee the Administrator for compliance and accuracy ongoing and continuous. The Quality Management Meeting will review monthly this regulation for ongoing compliance continually.

3-8-24 the audit was completed

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

185a Storage procedures

21. Requirements

2800.
185.a. The residence shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a Storage procedures *(continued)*

Description of Violation

The glucometer belonging to Resident #5 is not calibrated to the correct date and time.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Resident #5 a physician order was acquired, and a new Glucometer ordered.
The Wellness Director re-educated and trained LPN's and Medication Technicians to ensure all glucometers are calibrated to the correct date and time.
The Wellness Director will audit all glucometers for accuracy in calibrations for dates and times, and to ensure proper functioning of all equipment at time of changeover.
The Administrator will oversee The Wellness director at time of monthly changeover ongoing and continuous.
The Corporate RN will oversee The Wellness Director monthly ongoing and continuous. This regulation will be reviewed monthly at The Quality Management meeting for ongoing and continued compliance.

3-21-24 glucometer was replaced.
3-8-24 trainings and audit was completed

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

187a Medication record

22. Requirements

2800.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

Description of Violation

The glucometer of Resident #5 had a Blood Glucose reading of 227 on 1/7/2 (correct date is 2/7/24) at 6:59pm; 229 is indicated on the MAR.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Resident #5 was addressed with all LPN's and Medication Technicians and MAR was corrected.
Re-educated and trained all LPN's and Medication Technicians on accuracy with their documentation of blood glucose readings. weekly
The Wellness Director will audit all Glucometers to the MAR to verify accurate documentation at monthly change over.
The Administrator will oversee The Wellness Director at changeover ongoing and continuous.
Corporate RN to audit and oversee The Glucometers weekly ongoing and continuous. At The Quality Management meeting the medication record regulation will be reviewed and ensure accuracy is maintained ongoing and continually.

3-7-24 Resident MAR's completed, staff were trained on 3-7-24 and an audit was completed on 3-7-24

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

187d Follow prescriber's orders

23. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

The Medication Administration Record (MAR) for Resident #6 was not initialed by staff to indicate that the following medications were administered to the on 2/13/24 at 2000 hrs. (8:00pm) as prescribed:

1. Fluticasone Propionate nasal spray; 2 sprays at bedtime.
2. Melatonin tab. 3mg. at bedtime.
3. Metoprolol Succinate 100mg. 1 tab. daily at 8:00pm.
4. Acetaminophen Capsule 500mg. 3x daily

Resident #7's MAR has instructions to "make sure PACEMAKER BOX is plugged in every shift". Staff did not initial the MAR on 2/5/24 and 2/11/ 24 on the night shift to indicate the instructions were followed.
The Medication Administration Record (MAR) for Resident #8 was not initialed by staff on 2/13/24 at bedtime (2000 hrs.) to indicate that the Mirtazapine 30mg. tab was administered as ordered.

The (MAR) for Resident #8 is not initialed by staff on 2/13/24 at bedtime (2000 hrs.) to indicate that the resident's Blood Pressure was checked and recorded as ordered.

Resident #9 is prescribed Gabapentin 300 mg. capsule 2x daily (9:00am and 2:00pm). On 2/8/24 and 2/12/24 the resident's MAR is not initialed by staff to indicate the medication was administered at 2:00pm as ordered.

Repeat Violation - 3-9-2023, et al.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: MARs were corrected.
The Wellness Director audited all MARs for accuracy.
All corrections were made.
All Medication Technicians and LPNs were re-educated and re-trained on proper administration documentation of medications and MAR's.
All Medication Technicians and LPNs were re-educated and instructed to re-check all MAR's before leaving their shift.
At change of shift report both Medication Technician and or LPNs shall verify the MAR for accuracy
The Wellness Director will audit the MARs for the previous day ongoing and continuous.
The Administrator will oversee the audits of The Wellness Director monthly at end of month ongoing and continuous.
The Corporate RN will oversee the MAR's quarterly ongoing and continuous. At The monthly Quality Management Meeting this regulation will be reviewed to ensure ongoing compliance continually.

3-7-24 MARs corrected
3-7-24 Staff trained
3-7-24 Audit completed

Licensee's Proposed Overall Completion Date: *03/21/2024*

187d Follow prescriber's orders *(continued)*

Not Implemented [redacted] - 03/26/2024)

225a Assessment - RN/form

24. Requirements

2800.
225.a. The administrator or administrator designee, or an LPN, under the supervision of an RN, or an RN shall complete additional written assessments for each resident. A residence may use its own assessment form if it includes the same information as the Department's assessment form. Additional written assessments shall be completed as follows:

Description of Violation

Resident #1's most recent Assessment and Support Plan (ASP) is dated 7-14-22, exceeding the annual evaluation requirement.

Repeat Violation - 7-20-2023, 8-23-2023, 11-28-2023, et al.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Resident #1 was corrected with a new updated ASP.

Plan: Audited all current ASPs for accuracy for annual written assessments. Corrections were made and noted for POC for ASP's not in compliance.

A spreadsheet was developed to track dates of initial, annual and significant changes for all ASP's.

Within 48 hours all ASP's will have any significant change noted on the addendum by the Wellness Director

The Director of Wellness is responsible for this regulation and will complete same timely for compliance.

The Administrator will oversee the Wellness Director ongoing and continuous

The Administrator will audit the ASP's monthly to ensure compliance, the Administrator will monitor ongoing and continuous

The Corporate RN will oversee the Administrator ongoing and continuous. The monthly Quality Management Meeting will ensure all ASPs are current and updated ongoing and continually.

3-04-24 ASP was completed by DOW

3-15-24 audit was completed by DOW

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

227d Support plan – med/dental

25. Requirements

2800.
227.d. Each residence shall document in the resident's final support plan the dietary, 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 residence to pay for the cost of these medical and behavioral care services. The final support plan must document the assisted living services and supplemental health care services, if applicable, that will be provided to the resident.

227d Support plan – med/dental *(continued)*

Description of Violation

Resident #2 is identified in resident demographics as needing a specialized diet. The Assessment and Support Plan (ASP) dated 7-12-23 does not address his dietary requirements of a mechanical soft / ground diet.
Resident #3 is identified in resident demographics as needing and having a roam alert. The Assessment and Support Plan (ASP) dated 11/20/30 does not identify this need.
Repeat Violation - 3-9-2023, et al.

.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: Resident #2 and Resident # 3 ASPs were updated immediately.
All ASPs were audited and updated with corrections by The Director of Wellness
All ASPs are to be completed at time of admission as an initial ASP by the Director of Wellness for the final support plan.
The Wellness Director will audit all ASP's monthly ongoing and continuous.
The Administrator will audit The Wellness Director quarterly ongoing and continuous. The Administrator will monitor ongoing and continuous for compliance. The Corporate RN will monitor ongoing and continuous for compliance.
The Quality Management monthly meeting on the 18th of every month will ensure ongoing compliance is maintained and updates will be made at this time ongoing and continually.

_____

Resident #2 and Resident # 3 ASP was updated on 3-7-24
Audit was completed 3-7-24

Licensee's Proposed Overall Completion Date: *03/21/2024*

Not Implemented [redacted] - 03/26/2024)

252 Records – content

26. Requirements

2800.
252. Content of Resident Records - Each resident's record must include the following information:
3. A photograph of the resident that is no more than 2 years old.

Description of Violation

Resident #1 's file photo is dated 1-7-22, exceeding the 2-year requirement.
Resident # 4's file photo is date 1-7-22, exceeding the 2-year requirement.

Plan of Correction ***Accept [redacted] - 03/26/2024)***

Immediate Action: All Residents' Photographs were taken at the Community for this Plan of Correction as a baseline for compliance to establish a new date by the Activities Director, the Wellness Secretary uploaded same to the

252 Records – content (continued)

current Resident electronic record.

Plan: within 2 years a new picture will need to be taken on the same existing Residents if they remain a Resident at Luther Ridge by the Activities Director. The Wellness Secretary will upload all Resident pictures to the electronic medical record for the current residing Resident. All new admission Resident Pictures will be taken by the Sales and Marketing Director and uploaded by The Wellness Secretary.

The Administrator will oversee the Wellness Secretary, the Sales and Marketing Director, and the Activities Director ongoing and continuous for compliance.

Consulate Corporate RN will oversee ongoing and continuous. The contents of Resident records will be reviewed for ongoing compliance monthly at our Quality Management meeting and any corrections will be made monthly at this time ongoing and continually.

3-13-24 all Resident's photos were completed and 3-14-24 The Director of Wellness completed an audit for completion and accuracy.

Licensee's Proposed Overall Completion Date: 03/20/2024

Not Implemented [redacted] - 03/26/2024)

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *04/17/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *PA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *92* **Waking Staff:** *69*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *02/14/2024*

Inspection Dates and Department Representative

02/08/2024 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *77*

Special Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *76*

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

Have Mobility Need: *15* **Have Physical Disability:** *0*

Inspections / Reviews

02/08/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *03/01/2024*

03/26/2024 - POC Submission

Submitted By: [redacted]

Date Submitted: *03/26/2024*

Reviewer: [redacted]

Follow-Up Type: *Bypass Document Submission*

03/26/2024 - Bypass Document Submission

Submitted By: [redacted]

Date Submitted: *03/26/2024*

[redacted]

Follow-Up Type: *Enforcement*

42b Abuse/Neglect

1. Requirements

2800.
42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

On 2/4/23 at 4:30pm, Staff member "A" saw Staff member "B" push Resident #1 in [redacted] wheelchair into the resident's room and close the door behind them. Staff member "A" became suspicious and tried to enter the room, but it was locked. Using a master key, Staff member "A" entered Resident #1's room and found it to be dark. They turned the light on and saw Staff Member "B" sitting on the edge of the bed with Resident #1. Resident #1 was naked from the waist down. When asked what they were doing, Staff member "B" stated Resident #1 urinated on themself and [redacted] was helping Resident #1 change their clothes. Staff member "A" told Staff member "B" to leave the room. Staff member "A" asked Resident #1 if [redacted] was forced to do anything. Resident #1 replied "no" and that they had been having sex with Staff member "A" for a while.

Plan of Correction ***Accept [redacted] - 03/01/2024)***

Luther Ridge At Seiders Hill holds Resident safety at the highest regard, therefore we are respectfully submitting the following plan of correction:
** Due to the allegation's severity, Staff B was suspended [redacted] /24 and terminated on [redacted] /24*
**The Administrator immediately notified BHSL and Protective Services, followed with written reports to same.*
** Due to the severity of the allegation Pennsylvania State Police were notified and on site 2/5/24, the criminal investigation unit from Pennsylvania State Police were also on site.*
**2/6/24 BHSL agent on site to speak with Staff and Residents for their investigation.*
**Administrator immediately conducted Training on APS/OPSA, ACT 70, BHSL reporting and Resident Rights on 2/5/24*
**POA was immediately notified*
**Resident's primary care physician was contacted, and Resident 1 received a sexual assault examination at [redacted] Hospital on [redacted] /24.*
**Resident interviews were conducted, and the results were negative, not cognizant Residents were given skin assessments and the results were negative.*
**Protective Services cited Luther Ridge at Seiders Hill with Caregiver Neglect.*
** Per the Pennsylvania State Police, the case remains active.*
**Administrator will monitor compliance via QA reports quarterly ongoing and continuous.*
**New Staff will be trained during orientation ongoing and continuous.*

Licensee's Proposed Overall Completion Date: *02/27/2024*

Implemented [redacted] - 03/26/2024)

65e Rights/Abuse 40 Hours

2. Requirements

2800.
65.e. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:

Description of Violation

Staff person "B", hired on [redacted] /23, did not have the following orientation training within 40 scheduled working hours:

65e Rights/Abuse 40 Hours (continued)

(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. §§ 10225.101-10225.5102).
(4) Reporting of reportable incidents and conditions.
(5) Safe management techniques.
(6) Core competency training that includes the following:
i. Person-centered care.
ii. Communication, problem solving and relationship skills.
iii. Nutritional support according to resident preference.
Only training in Residents Right was completed.

Plan of Correction ***Accept (- 03/25/2024)***

**Staff Person B is no longer with the company.*
** Non-Training Compliance was audited for current ancillary employees.*
**Staff persons cannot begin unsupervised work duties until there is a completion of trainings for newly hired staff*
**Trainings must include a demonstration of job duties as well as the education component.*
**Training for new hires was revised by Administrator to meet the regulation for compliance*
** Administrator will report results to Wellness Secretary monthly for the Quality Review to be completed.*
** The Wellness Secretary will meet the Administrator monthly to review compliance*
**The Administrator will oversee ongoing and continuous*

Licensee's Proposed Overall Completion Date: *02/27/2024*

Not Implemented - 03/26/2024)

65f Ancillary staff orientation

3. Requirements

2800.
65.f. Ancillary staff persons shall have a general orientation to their specific job functions as it relates to their position prior to working in that capacity.

Description of Violation

Staff person "B", hired as an Aide on /23, did not have a general orientation to their specific job functions as it relates to their position.

Plan of Correction ***Accept - 03/25/2024)***

**Staff person B is no longer with the company*
** Non-Training Compliance was audited for current ancillary employees*
**Staff persons cannot begin unsupervised work duties until there is a completion of trainings for newly hired staff.*
**Trainings must include a demonstration of job duties.*
**Ancillary staff must have a general orientation to their specific job function prior to beginning unsupervised work duties.*
**The Administrator will meet directly with the Manger of a newly hired ancillary staff person to ensure that the staff person has a general orientation prior to begin unsupervised work duties.*

Licensee's Proposed Overall Completion Date: *02/27/2024*

Not Implemented - 03/26/2024)

65f Ancillary staff orientation *(continued)*

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

Facility Information

Name: *LUTHER RIDGE AT SEIDERS HILL* **License #:** *22466* **License Expiration:** *04/17/2024*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA 17901*

County: *SCHUYLKILL* **Region:** *NORTHEAST*

Administrator

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

Legal Entity

Name: *LUTHER RIDGE FACILITY OPERATIONS LLC*

Address: *160 RED HORSE ROAD, POTTSVILLE, PA, 17901*

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

Certificate(s) of Occupancy

Type: *C-2 LP* **Date:** *06/23/1999* **Issued By:** *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff:** *91* **Waking Staff:** *68*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *01/18/2024*

Inspection Dates and Department Representative

01/18/2024 - On-[redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *135* **Residents Served:** *69*

Special Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *68*

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

Have Mobility Need: *22* **Have Physical Disability:** *0*

Inspections / Reviews

01/18/2024 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *02/08/2024*

02/12/2024 - POC Submission

Submitted By: [redacted] **Date Submitted**: *02/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *02/17/2024*

03/26/2024 - Document Submission

Submitted By: [redacted] **Date Submitted**: *02/15/2024*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

3d Post license/VR/Regs

1. Requirements

2800.
3.d. The assisted living residence 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 assisted living residence.

Description of Violation

The home did not have their current provisional license posted conspicuously in the home as required.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

Immediate action; the current provisional license posted on main floor of the community on the information board on 1/18/2024.
Plan; Administrator to monitor weekly for compliance beginning on 1/18/2024
The administrator will perform a visual inspection for all inspection summaries weekly.
The administrator will monitor same ongoing and continually.

Licensee's Proposed Overall Completion Date: *02/08/2024*

Not Implemented [redacted] - 02/22/2024)

42c Dignity/Respect

2. Requirements

2800.
42.c. A resident shall be treated with dignity and respect.

Description of Violation

Based on an interview with resident #1, it was determined that staff person A did not treat the resident with dignity and respect. According to resident #1 staff person A would get frustrated with the resident while providing care and would also refuse to allow resident #1 to use their walker to assist with transferring from bed to standing.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

Immediately: Staff person A was re-educated on regulation 42(c) as well as all Resident Rights . Staff A was trained in body mechanic by Powerback rehab on body mechanics.
Plan: Facility personnel re-educated on Resident Rights on 1/18/2024.
The administrator will monitor daily that regulation followed.
The administrator is responsible that regulation 42c is followed daily. The administrator will monitor ongoing and continually.

Licensee's Proposed Overall Completion Date: *02/08/2024*

Implemented ([redacted] - 02/22/2024)

251b Record entries - legible

3. Requirements

2800.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

The document of medical evaluation form, or ADME dated 6/14/23 for resident #2 had correction fluid over the

251b Record entries - legible (continued)

original date of the resident's TB test that was documented on the form.

Plan of Correction ***Accept [redacted] - 02/12/2024)***

Immediate action: The facility dispose of all the white onsite on 1/18/2024.
Plan: Staff re-educated and trained on proper documentation procedures 1/18/2024.
The wellness secretary will review monthly all documentation is legible . The administrator will over see the wellness secretary on-going and continually

Licensee's Proposed Overall Completion Date: *02/08/2024*

Implemented [redacted] - 02/22/2024)