

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

June 17, 2025

[REDACTED], ADMINISTRATOR
CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH
1600 GEORGETOWN DRIVE
SEWICKLEY, PA, 15143

RE: CONCORDIA OF FRANKLIN PARK
1600 GEORGETOWN DRIVE
SEWICKLEY, PA, 15143
LICENSE/COC#: 44363

Dear [REDACTED]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 05/08/2025, 05/09/2025 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 FRANKLIN PARK* License #: *44363* License Expiration: *03/15/2026*
 Address: *1600 GEORGETOWN DRIVE, SEWICKLEY, PA 15143*
 County: *ALLEGHENY* Region: *WESTERN*

Administrator

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

Legal Entity

Name: *CONCORDIA LUTHERAN MINISTRIES OF PITTSBURGH*
 Address: *1600 GEORGETOWN DRIVE, SEWICKLEY, PA, 15143*
 Phone: [REDACTED] Email: [REDACTED]

Certificate(s) of Occupancy

Type: *C-2 LP* Date: *08/11/1998* Issued By: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* Total Daily Staff: *71* Waking Staff: *53*

Inspection Information

Type: *Full* Notice: *Unannounced* BHA Docket #:
 Reason: *Renewal, Complaint* Exit Conference Date: *05/09/2025*

Inspection Dates and Department Representative

05/08/2025 - On-Site: [REDACTED]
 05/09/2025 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information
 License Capacity: *100* Residents Served: *56*

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

Hospice
 Current Residents: *11*

Number of Residents Who:
 Receive Supplemental Security Income: *0* Are 60 Years of Age or Older: *56*
 Diagnosed with Mental Illness: *0* Diagnosed with Intellectual Disability: *0*
 Have Mobility Need: *15* Have Physical Disability: *2*

Inspections / Reviews

05/08/2025 - Full
 Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/13/2025*

Inspections / Reviews (*continued*)

06/17/2025 - POC Submission

Submitted By: [REDACTED] Date Submitted: 06/17/2025
Reviewer: [REDACTED] Follow-Up Type: *Bypass Document
Submission*

06/17/2025 - Bypass Document Submission

Submitted By: [REDACTED] Date Submitted: 06/17/2025
Reviewer: [REDACTED] Follow-Up Type: *Not Required*

65f - Training Topics

1. Requirements

2600.

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

Description of Violation

Staff persons B and C did not receive medication self-administration training during training year 2024.

Plan of Correction

Accepted (█ - 06/17/2025)

Staff persons B and C were immediately trained on Medication Self-Administration by the Resident Care Coordinator using the attached information on 5/9/2025 (entire training not attached, only excerpt related to this topic - can provide entire training if requested). Signature sheet is attached. Medication Self-Administration training is on the 2025 Staffing Training Plan for December, a copy of the plan is attached. Administrator or designee will audit completion of assigned trainings monthly to ensure regulatory compliance. Records of completed trainings will be maintained. The monthly audits began in January of 2025 and will continue monthly for remainder of the year. Training completion will be reviewed quarterly at the QA meeting, next one is scheduled for 07/22/2025 at 3pm. Minutes from QA meetings will be maintained.

Licensee's Proposed Overall Completion Date: 06/11/2025

Implemented (█ - 06/17/2025)

100a - Exterior - Free of Hazards

2. Requirements

2600.

100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 5/8/25, at 10:28 a.m., the exterior sidewalk is uneven and cracked, across the width of the sidewalk, at the ramp located near the north hallway emergency exit, posing a trip/fall hazard.

Plan of Correction

Accepted (█ - 06/17/2025)

This ramp was already scheduled to be replaced but the project was unable to be started during the winter months. Work on the ramp began on 06/06/2025. This emergency exit is currently closed - updated evacuation map has been posted in the affected hallway, affected residents in north hallway were informed of the closure via in person conversation & demonstration of new evacuation route on 06/06/2025. A sign was posted on the door indicating that is not an exit and a board was placed on the outside of the door to prevent door from opening. Fire department was notified of this change on 6/6/2025 via attached letter. Project is anticipated to last 8 weeks. Unannounced fire drills will continue monthly and administrator or designee will observe the north hallway to ensure residents & staff do not attempt to utilize closed exit. If any issues observed, education will be immediately provided and another fire drill will be conducted in the same month to ensure safe evacuation practices. Administrator will advise fire department upon completion of the project. Records of all fire drills will be maintained. An Audit of the exterior and building grounds will be completed monthly by Administrator or designee. This will begin on 6/11/2025 and will occur monthly for 6 months and then quarterly on an ongoing basis. Audit records will be maintained and will be reviewed quarterly at the QA meeting, next meeting scheduled for 7/22/25. QA meeting minutes will also be maintained.

Licensee's Proposed Overall Completion Date: 08/01/2025

Implemented (█ - 06/17/2025)

121a - Unobstructed Egress

3. Requirements

2600.

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

Description of Violation

On 5/8/25, at 10:53 a.m., there was a "Stop" sign posted on the inside of the door and outside the door, there is fenced area enclosed by latched gate, blocking immediate egress from the building from the emergency exit door located in the garden south area of the home.

Plan of Correction

Accept (█) - 06/17/2025

The Stop sign was immediately removed on 5/8/2025 by Administrator. The door to the gate in question was secured open to avoid delaying egress in event of emergency, due to absence of maintenance director. On 5/12/2025 the latch was completely removed from this gate by the maintenance director, allowing for continued immediate egress from the building. Pictures attached to include stop sign removal and gate without latch. Administrator and/or designee will conduct a monthly audit of all egress routes to ensure they are unlocked and unobstructed beginning June 11, 2025 and continuing monthly for 6 months then quarterly on an ongoing basis. Any identified issues will be resolved. Records of audits will be maintained. Results of the audits will be reviewed in the quarterly QA meeting, next one scheduled for 07/22/2025. Minutes of the QA meeting will be maintained.

Licensee's Proposed Overall Completion Date: 11/11/2025

Implemented (█) - 06/17/2025

185a - Implement Storage Procedures

4. Requirements

2600.

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

Description of Violation

On 5/8/25, at 2:36 p.m., resident #1's glucometer was not calibrated to the current date and time.

Plan of Correction

Accept (█) - 06/17/2025

The glucometer was immediately replaced with a new one by a Resident Care Coordinator upon discovery on 5/8/25. Glucometer audits had been assigned to be completed weekly but this was not completed in this resident's case. Staff person was educated on importance of completing assigned tasks to ensure accuracy and regulatory compliance on 6/11/2025. Audits continue to be completed weekly by LPNs. All audit records will be maintained. Resident Care Coordinators will monitor audit completion monthly for trends/issues/education opportunities for staff. Med Techs and LPNs will be educated within 7 days of approved plan of correction on procedure for calibrating glucometers and reporting any discrepancies. A record of this training will be maintained. Results of audits will be reviewed in quarterly QA meetings - next meeting scheduled for 7/22/25.

Licensee's Proposed Overall Completion Date: 06/27/2025

Implemented (█) - 06/17/2025

224a - Preadmission Screen Form

5. Requirements

224a - Preadmission Screen Form (continued)

2600.

224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #2's preadmission screening form, dated [REDACTED], was not signed by the individual completing the form.

Plan of Correction

Accept ([REDACTED] - 06/17/2025)

Staff person who completed the prescreen in question was educated on 5/10/25 by Administrator - see attached record of training. Administrator audited 10 additional resident Preadmission Screen Forms for signature and found no further violations on 6/10/2025. Administrator or designee will audit all preadmission paperwork for completion no later than day of admission to ensure regulatory compliance. This will be an ongoing measure beginning with all admissions as of 6/11/2025.

Licensee's Proposed Overall Completion Date: 06/13/2025

Implemented ([REDACTED] - 06/17/2025)

251b - Record Entries Legible

7. Requirements

2600.

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

There was correction fluid used on the resident signature block of resident #3's assessment and support plan, dated [REDACTED]

Plan of Correction

Accept ([REDACTED] - 06/17/2025)

Completing staff person had erroneously signed in the resident spot. Staff person was educated on the proper method to make corrections to errors on documents on 5/10/25 (see attached record of training). Administrator audited the charts of 10 random residents to determine if any other instances had occurred and no additional violations were found. Administrator or designee will audit 5 resident charts per month for 3 months to ensure there are no further instances of this violation.

Licensee's Proposed Overall Completion Date: 09/12/2025

Implemented ([REDACTED] - 06/17/2025)