

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395816	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Lutheran Home at Kane, The		STREET ADDRESS, CITY, STATE, ZIP CODE 100 High Point Drive Kane, PA 16735	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records, and staff interview it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of 18 residents reviewed (Residents R1, R3, and R77). Findings include: Review of facility policy entitled Transfer or Discharge, Emergency dated 11/3/25, indicated Should it become necessary to make emergency transfer or discharge to a hospital or other related institution, our facility will prepare a transfer packet to send with the resident that includes; face sheet, administration record, order summary, bed hold policy, immunization report, recent weight and vitals, copy of advance directives, and complete e-interact form. Resident R1's clinical record revealed an admission date of 8/27/25, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), atrial fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing). Resident R1's progress notes revealed a note dated 8/29/25, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R3's clinical record revealed an admission date of 12/30/24, with diagnoses that included hypertension (high blood pressure), hyperlipidemia (high cholesterol), and heart failure (a condition where the heart cannot supply the body with enough blood). Resident R3's progress notes revealed notes dated 5/18/25, 8/11/25, and 8/14/25, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R77's clinical record revealed an admission date of 8/25/25, with diagnoses that included weakness, dysphagia (difficulty swallowing), and chronic respiratory failure. Resident R77's progress notes revealed a note dated 9/5/25, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 11/19/25, at 9:09 a.m. the Director of Nursing confirmed that Residents R1, R3, and R77s clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider upon transfer and when the transfers occurred clinical information should have been provided to the receiving healthcare provider. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for two of four residents reviewed for respiratory care (Residents R4 and R49). Findings include: Review of facility policy entitled Oxygen Administration dated 11/3/25, indicated Concentrator filters cleaned weekly on night shift. Review of resident R4's clinical record revealed an admission date of 8/8/25, with diagnoses that included chronic obstructive pulmonary disease (COPD) (a disease that obstructs air flow from the lungs), heart failure (a condition where the heart cannot supply the body with enough blood), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R4's physician's orders revealed an order dated 8/8/25, for oxygen between two and four liters via nasal cannula (oxygen tubing that has prongs that go into the nostrils and loops around the ears to secure in place to ensure adequate oxygen delivery) continuously. Review of Resident R4's care plan for COPD revealed an intervention of oxygen between two and four liters continuously. Review of Resident R4's tasks (an area in the clinical record where nursing assistant document) revealed a task for oxygen tubing/cannula change/concentrator filter cleaned. Observations on 11/17/25, at 1:55 p.m. and again at 2:25 p.m. revealed Resident R4 lying in his/her bed with oxygen being administered. Further observations revealed a filter on the back of his/her oxygen concentrator that had a large amount of a fluffy white substance covering the filter. Review of Resident R49's clinical record revealed an admission date of 12/5/25, with diagnoses that included COPD, congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), and chronic respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R49's physician's orders revealed an order dated 4/15/19, for oxygen at two liters via nasal cannula every evening and night shift. Review of Resident R49's care plan for congestive heart failure revealed an intervention of oxygen at two liters per minute at hour of sleep. Review of Resident R49's tasks revealed a task for oxygen tubing/cannula change/concentrator filter cleaned. Observations on 11/17/25, at 1:08 p.m. and again at 2:25 p.m. revealed Resident R4's oxygen concentrator sitting in his/her room with the nasal cannula lying over the concentrator and the nasal cannula touching the floor. Further observations revealed a filter on the back of his/her oxygen concentrator that had a large amount of a fluffy white substance covering the filter. During an interview on 11/17/25, at 2:32 p.m. Registered Nurse (RN) Employee E1 confirmed that Resident's R4 and R49's oxygen concentrator filters were covered in a large amount of a white fluffy substance and that Resident R49's nasal cannula was touching the floor. RN Employee E1 also confirmed that the oxygen concentrator filters should be clean, and the nasal cannula should not be on the floor. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policies, observations, and staff interview it was determined that the facility failed to appropriately discard outdated medications for one of two medication carts reviewed (300 hall medication cart). Findings include: Review of facility policy entitled Storage of Medications dated 11/3/25, indicated Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Review of manufacturer's guidelines revealed that an open pen of Lispro Insulin must be used within 28 days after opening or be discarded, even if the vial still contains insulin. Observation of drug storage on 11/17/25, at 12:55 p.m. of the 300-hall medication cart revealed an open Lispro Insulin pen with an open date of 10/3/25, and an expiration date of 10/31/25. During an interview on 11/17/25, at the time of observation Licensed Practical Nurse Employee E2 confirmed that the open Lispro insulin pen was beyond the expiration date and also confirmed that the insulin pen should have been discarded. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services		