

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395816</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/19/2024</b>
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NAME OF PROVIDER OR SUPPLIER: <b>LUTHERAN HOME AT KANE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>100 HIGH POINT DRIVE KANE, PA 16735</b>
STATE LICENSE NUMBER: <b>902802</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0761 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, and a Civil Rights Compliance Survey completed on December 19, 2024, it was determined that The Lutheran Home at Kane was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0761		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0761  SS=D	Continued from page 1  483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by:	F 0761	It is the practice of this facility to ensure drugs and biologicals are stored properly. Immediately upon notification of unlabeled open PPD solution, open solution was discarded. All PPD inventory was checked for opened bottles with no open date.  All licensed nursing staff to be educated by the DON/designee regarding the handling of the administration of PPD solution with emphasis on the importance of dating vials upon opening by 1/31/2024.  Staff will be provided with clear reminders to date open PPD vials. The DON/designee to audit the medication refrigerators weekly x 4 weeks, monthly x 3 months, and quarterly x 2 quarters to assure ongoing compliance. This corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program (QAPI). Findings will be submitted to the QAPI Committee for review	Completion Date: <b>01/31/2025</b> Status: <b>APPROVED</b> Date: <b>12/27/2024</b>

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F 0761  SS=D	Continued from page 2	F 0761	and follow up.		

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F 0761  SS=D	Continued from page 3  Based on review of facility policy, manufacturer's recommendations, observations, and staff interview, it was determined that the facility failed to ensure that medications were properly dated when opened and discarded in a timely manner in one of two medication rooms reviewed (200-Hall medication storage room).  Findings include:  Review of a facility policy entitled "Labeling of Medication Containers" dated 12/05/24, revealed "Labels for stock medications include all necessary information, such as: d. The expiration date when applicable."  Manufacturer's recommendations for Aplisol PPD (solution used for tuberculosis testing upon admission and for employment), indicated that vials in use for more than 30 days should be discarded due to possible oxidation and degeneration which may affect potency.	F 0761		

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F 0761  SS=D	Continued from page 4  Observations of drug storage on 12/17/24, at approximately 3:46 p.m. in the 200-Hall medication storage room refrigerator revealed one open vial of Aplisol without an opened date, therefore the staff were unable to determine the discard date.  During an interview at that time, Licensed Practical Nurse Employee E1 confirmed that the open Aplisol vial lacked an opened date and staff were unable to determine the discard date.  28 Pa. Code 211.9(a)(1) Pharmacy services  28 Pa. Code 211.10(c) Resident care policies  28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0761		

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P 5520		P 5520		

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P 5520	Continued from page 1  Nursing services.  (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.  This REGULATION is not met as evidenced by:	P 5520	All residents received appropriate care and services to meet their needs on the identified days of 7/2, 7/4, 7/5, 7/7, 11/7, 12/12, 12/13, 12/14, 12/15 where minimal staffing ratio was not met, but PPD was met on all days.  Residents of The Lutheran Home at Kane will be protected from future nurse aide staff ratios below the 1:10 nurse aide for days, 1:11 nurse aide for evenings and 1:15 for nights by a proactive preview of daily staff assignments and schedules to ensure adequate staff coverage by DON/Designee.  The scheduler or designee will review projected staffing levels and audit to ensure staffing levels were met with the Director of Nursing or designee, 3 times a week x2 weeks, two times a week x2 and then monthly X2 months to ensure that any foreseeable staffing levels below nurse aide ratios are adequately covered.  The Lutheran Home will continue to	Completion Date: <b>02/07/2025</b> Status: <b>APPROVED</b> Date: <b>01/02/2025</b>

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P 5520	Continued from page 2	P 5520	<p>aggressively advertise externally for the recruitment of nursing assistant applicants to enhance current staffing levels. The Lutheran Home at Kane is an approved site of the Pennsylvania Nurse Aide Training and Competency Evaluation Program and has ongoing nurse aide training classes quarterly. The Lutheran Home has 8 NA students who are ready to complete their skills testing and have yet to be able to complete the testing as their tests have been cancelled several times. The Lutheran Home has scheduled them at different sites and the tests are still being consistently cancelled.</p> <p>This plan of correction will be followed but call offs and no call no shows are unpredictable, and we continue to cover them to the best of our abilities.</p> <p>The Lutheran Home is currently offering call-in incentives to entice employees to pick up unscheduled shifts and has instituted a positive points program as an incentive. The</p>	

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P 5520	Continued from page 4  Based on review of the facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Nurse Aide (NA) per 10 residents for the day shift for two of 21 days reviewed (7/07/24 and 12/14/24); failed to ensure a minimum of one NA per 11 residents for the evening shift for one of 21 days reviewed (12/13/24); and failed to ensure a minimum of one NA per 15 residents for the overnight shift for eight of 21 days reviewed (7/02/24, 7/04/24, 7/05/24, 7/07/24, 11/07/24, 12/12/24, 12/13/24, and 12/15/24).  Findings include:  Review of facility nursing staffing documents for the time periods from 7/01/24 through 7/07/24, 11/01/24 through 11/07/24, and 12/12/24 through 12/18/24, revealed the following NA staffing shortages for the day shift where the NA ratios were not met:  7/07/24                      census of 72 residents	P 5520		

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P 5520	<p>Continued from page 5</p> <p>6.93 NAs worked and 7.20 were required 12/14/24 census of 73 residents 6.67 NAs worked and 7.30 were required</p> <p>Review of facility nursing staffing documents for the time periods from 7/01/24 through 7/07/24, 11/01/24 through 11/07/24, and 12/12/24 through 12/18/24, revealed the following NA staffing shortage for the evening shift where the NA ratios were not met:</p> <p>12/13/24 census of 73 residents 6.10 NAs worked and 6.64 were required</p> <p>Review of facility nursing staffing documents for the time periods from 7/01/24 through 7/07/24, 11/01/24 through 11/07/24, and 12/12/24 through 12/18/24, revealed the following NA staffing shortages for the overnight shift where the NA ratios were not met:</p> <p>7/02/24 census of 73 residents 4.23 NAs worked and 4.87 were required</p>	P 5520		

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P 5520	Continued from page 6  7/04/24 census of 73 residents 4.83 NAs worked and 4.87 were required 7/05/24 census of 73 residents 4.74 NAs worked and 4.87 were required 7/07/24 census of 72 residents 4.20 NAs worked and 4.80 were required 11/07/24 census of 76 residents 4.42 NAs worked and 5.07 were required 12/12/24 census of 73 residents 3.79 NAs worked and 4.87 were required 12/13/24 census of 73 residents 4.58 NAs worked and 4.87 were required 12/15/24 census of 72 residents 4.01 NAs worked and 4.80 were required  During an interview on 12/19/24, at 12:05 p.m. the Director of Nursing confirmed that the facility failed to meet the minimum NA ratio requirements on the dates and shifts listed above.	P 5520		



# Certified End Page

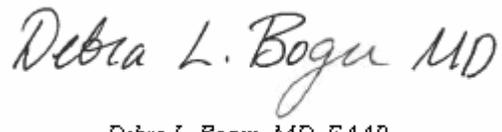
**LUTHERAN HOME AT KANE**

**STATE LICENSE NUMBER: 902802**

**SURVEY EXIT DATE: 12/19/2024**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY