January 16, 2020

Ms. Ellen Shrager
Executive Director
Lutheran Community at Telford
12 Lutheran Home Drive
Telford, Pennsylvania 18969

RE: Lutheran Community at Telford
235 North Washington Street
Telford, Pennsylvania 18969
License #: 126720

Dear Ms. Shrager:

As a result of the Department's Bureau of Human Services Licensing annual inspection on June 10 and 11, 2019 and September 10 and 11, 2019 of the above facility, the violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes) must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to https://www.surveymonkey.com/r/BHSL_Inspection.

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

Kevin Hancock
Deputy Secretary
Office of Long-term Living

Enclosure
Violation Report

Violation Report

Facility Information

Name: LUTHERAN COMMUNITY AT TELFORD — License Number: 126720
Address: 235 NORTH WASHINGTON STREET, TELFORD, PA 18969
County: BUCKS — Region: SOUTHEAST

Administrator

Name: Malissa Stroble — Phone: 2157239819 — Email: ESHRAGER@LCTELFORD ORG / mstroble@lctelford.org

Legal Entity

Name: LUTHERAN COMMUNITY AT TELFORD
Address: 12 LUTHERAN HOME DRIVE, TELFORD, PA, 18969

Certificate(s) of Occupancy

Type: I-2 — Date: 08/06/2012 — Issued By: Borough of Telford

Staffing Hours

Resident Support Staff: 0 — Total Daily Staff: 101 — Waking Staff: 76

Inspection

Type: Full — BHA Docket #: — Notice: Unannounced
Reason: Renewal

Inspection Dates and Department Representative

06/10/2019 - On-Site: Dean Gray, Youn Hie Chung
06/11/2019 - On-Site: Dean Gray, Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 125 — Residents Served: 77

Secured Dementia Care Unit

In Home: Yes — Area: Shepards Way — Capacity: 26 — Residents Served: 24

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0
Are 60 Years of Age or Older: 77
Diagnosed with Mental Illness: 30
Diagnosed with Intellectual Disability: 0
Have Mobility Need: 24
Have Physical Disability: 3

15b - Supervisor Plan

Regulations

2600.

15.b. If there is an allegation of abuse of a resident involving a home's staff person, the home shall immediately develop and implement a plan of supervision or suspend the staff person involved in the alleged incident.

Description of Violation

On 04/24/19, staff person A, was involved in a suspected abuse incident with resident #1. The home suspended the staff person immediately but allowed the staff person to return from suspension without proper authorization from the department.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

I respectfully disagree with this issuance of this violation.

This alleged abuse allegation was reported to the Department of Health and Human Services in addition to Bucks County Area Agency on Aging. This allegation was investigated by a representative from Bucks County Area Agency on Aging. The representative came to the facility and conducted an interview with the resident, spoke with the Administrator and conducted a phone interview with the employee. Following the AAA investigation, the findings were reported to a AAA supervisor and another conversation confirmed there were no discrepancies with the facts from the facility's investigation and the Area Agency on Aging's investigation. It was agreed that there was no intentional abuse and based on the findings there was no threat of harm to this resident or any other resident and the allegation was deemed as unsubstantiated. The employee's suspension status was lifted, the employee returned to active employment and was compensated for any missed time due to the suspension status.

This abuse allegation was reported to the Department of Health and Human Services as required. There was no communication at the time of the report, through the investigation or following the outcome of the allegation from the Department. The employee was suspended, she did not return to work until the investigation was concluded and the allegation was deemed unsubstantiated by the AAA that did an investigation. It would not be beneficial to the resident, facility or employee to continue to keep the employee on a suspension status without compensation awaiting a response from the Department of Health and Human Services that did not communicate a concern at the time of the report or anytime thereafter.

Immediately: If any future allegations of abuse occur, the home will immediately-Place the accused staff person on a plan of supervision that is pre-approved by the Department, or suspend the staff person involved, Report the alleged abuse to the Department, Report the alleged abuse to the local Area Agency on Aging and Report the alleged abuse to the resident's designated person, if any. 1/2/20 MJ

Legal Entity Representative

Signature: Ellen Shrager

Printed Name and Title: ELLEN SHRAGER, EXECUTIVE DIRECTOR

Date: 7/16/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MJ (Initials)

Fully Implemented

Partially Implemented - Adequate Progress

X Partially Implemented - Inadequate Progress

Not Implemented

18 - Compliance With Laws

Regulations

2600.

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

Description of Violation

The home does not have a carbon monoxide detector in close proximity of, but not less than 15 feet from the fossil fuel burning appliances in the main kitchen as required under the Care Facility Carbon Monoxide Alarms Standards Act of June 23, 2016.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

We are working with Simplex JCI to have a carbon monoxide detector installed in the main kitchen area. We anticipate completion of this installation to be September 1, 2019. The carbon monoxide detector will be tied into the fire alarm panel. The Maintenance Director is responsible for ensuring compliance and timely completion of this installation.

Legal Entity Representative

Ellen Shrager — ELLEN SHRAGER, EXECUTIVE DIRECTOR — 7/16/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

The above plan of correction was approved by MJ (Initials)

Plan of correction implementation status as of 1/2/20 (Date)

X Fully Implemented

Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

28f - Resident's Funds and 30-day Refund

Regulations

2600.

28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #2 was discharged on 01/15/19. The home did not provide the required refund until 02/20/19.

Resident #3 was discharged on 09/25/18. The home did not provide the required refund until 11/01/18.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Controller and Finance dept. staff were educated on this regulation. A checklist was created (see attached) and will be monitored by the Administrator to ensure continued compliance going forward. All refunds due since the time of inspection have been issued within 30 days.

Maintain documentation of education and checklist for Department review. 1/2/20 MCJ

Legal Entity Representative

Ellen Shrager — ELLEN SHRAGER EXECUTIVE DIRECTOR — 7/16/19

Signature — Printed Name and Title — Date

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Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MCJ (Initials)

Fully Implemented

X Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

42s - Privacy

Regulations

2600.

42.s. A resident has the right to privacy of self and possessions. Privacy shall be provided to the resident during bathing, dressing, changing and medical procedures.

Description of Violation

On 06/10/19, the home has video recording of entrances, exits and interior non-private spaces. However, there are no signs posted in these areas indicating that images are being recorded.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The current signage states that the cameras are being monitored. New signage will be created stating that the cameras are recording and not just monitoring. Additional signage will be added to ensure residents, families and staff members are aware of the cameras in all locations. All new signs containing verbiage of recording will be placed by August 30, 2019. Continued compliance will be monitored by the Administrator.

Legal Entity Representative

[signature] Signature — ELLEN SHRAGER, EXECUTIVE DIRECTOR — Printed Name and Title — 7/16/19 Date

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The above plan of correction is approved as of 1/2/20 (Date)

The above plan of correction was approved by MJ (Initials)

Plan of correction implementation status as of 1/2/20 (Date)

Fully Implemented

X Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

65a - FS Orientation 1st Day

Regulations

2600.

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:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person B, whose first day of work was 04/01/19, did not receive orientation on the following topics: evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable, the location and use of fire extinguishers, smoke detectors and fire alarms, telephone use and notification of emergency services until 04/05/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The orientation process for new employees is currently being reviewed and changes are being made to the process. All new employees will attend a new hire orientation that will include all trainings that are required prior to the first work day. The new process will start September 1, 2019 in the interim the previous process will be monitored to ensure all required trainings are completed prior to the first work day. The Human Resources Coordinator will be responsible to ensure continued compliance.

Within 30 days receipt of this plan of correction - All staff persons involved in the hiring and retention of staff will be educated on the home's policy and procedures for new staff person training including the requirements of this regulation. Documentation of education will be kept. 1/2/20 MJ

Legal Entity Representative

Ellen Shrager — Signature

ELLEN SHRAGER EXECUTIVE DIRECTOR — Printed Name and Title

7/16/19 — Date

65a - FS Orientation 1st Day (continued)

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

The above plan of correction was approved by MC (Initials)

Plan of correction implementation status as of 1/2/20 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [X] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person C did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, emergency preparedness procedures and recognition and response to crises and emergency situations, resident rights, falls and accident prevention during training year 2018.

Staff person D did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, resident rights, falls and accident prevention during training year 2018.

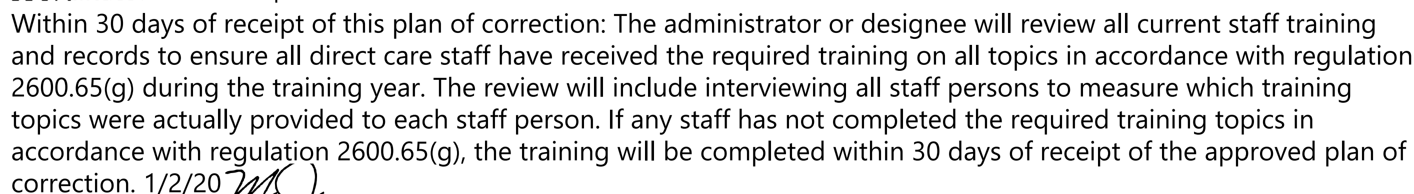
Staff person E did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, during training year 2018.

Staff person F did not receive training in fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert, during training year 2018.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The required mandatory training will be conducted live by varied sources with experience on the mandatory topic in addition to the training on RELIAS. The RELIAS training completion log will be reviewed quarterly by the scheduler to ensure staff are completing training on a consistent basis. Staff members that have not completed the mandatory trainings 2 months prior to their training year end date will be required to complete the trainings before being permitted to work. The Staffing Coordinator will be responsible to ensure continued compliance.


Within 30 days of receipt of this plan of correction: The administrator or designee will review all current staff training and records to ensure all direct care staff have received the required training on all topics in accordance with regulation 2600.65(g) during the training year. The review will include interviewing all staff persons to measure which training topics were actually provided to each staff person. If any staff has not completed the required training topics in accordance with regulation 2600.65(g), the training will be completed within 30 days of receipt of the approved plan of correction. 1/2/20

65g - Annual Training Content (continued)

Legal Entity Representative

Ellen Shrager ELLEN SHRAGER EXECUTIVE DIRECTOR 7/16/19

Signature Printed Name and Title Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MC (Initials)

Fully Implemented

Partially Implemented - Adequate Progress

X Partially Implemented - Inadequate Progress

Not Implemented

89b - Hot Water Temperature

Regulations

2600.

89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 06/11/19, the hot water temperature at the bathroom in room 114 measured 129.5 degrees Fahrenheit.

On 06/11/19, the hot water temperature at the bathroom in room 106 measured 130.1 degrees Fahrenheit.

On 06/11/19, the hot water temperature at the bathroom in room 225 measured 123.6 degrees Fahrenheit.

On 06/11/19, the hot water temperature at the bathroom in room 212 measured 124.1 degrees Fahrenheit.

On 06/11/19, the hot water temperature at the bathroom in room 239 measured 124.3 degrees Fahrenheit.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

There was a malfunction with the mixing valve that caused the elevated water temperatures. The mixing valve is scheduled to be replaced on 7/18/19 by IT Landis Co. The security staff members have been educated on the water temperatures parameters and whom to contact in the event of the water temperature readings being elevated to greater than 120 degrees. A security staff meeting is scheduled for 7/17/19 to address any further questions or concerns regarding water temperatures. Water temps since inspection have been within the required range. To ensure continued compliance the Maintenance Director will be doing periodic monitoring of the water temperatures.

Maintain documentation of water temperature audits for Department reveiw. 1/2/20 MCJ

Legal Entity Representative

Ellen Shlager	ELLEN SHLAGER EXECUTIVE DIRECTOR	7/16/19
Signature	Printed Name and Title	Date

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The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MCJ (Initials)

Fully Implemented

X Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

95 - Furniture and Equipment

Regulations

2600.

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

Description of Violation

The covers on the overhead lights outside the "A wing" exit were unsecure and hanging down from against the light presenting a hazard.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Inspection occurred at a time when the roof to the building was being replaced. The required banging to complete the roof dislodged the brackets that hold the overhead lights securely to the entranceway roof. It was noted that the dislodged brackets caused the lighting fixtures to suspend away from the roof. The maintenance team secured the lighting fixtures by pressing them back into place with the handle of a broom at the time of inspection. The covers have been monitored by the maintenance staff and there have been no other concerns.

Legal Entity Representative

[signature] ELLEN SHRAGER, EXECUTIVE DIRECTOR 7/16/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

Fully Implemented

X Partially Implemented - Adequate Progress

Partially Implemented - Inadequate Progress

Not Implemented

The above plan of correction was approved by MJ (Initials)

102k - No Common Towel

Regulations

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

There were no name tags for the towels hanging in the shared bathroom of rooms #109 and #111.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

The Personal Care staff members have been reminded about this regulation. A notation will be added to the shower schedule to remind staff to check for name labels on each shared bathroom towel bar. The housekeeping staff will also check for the name label on each shared bathroom towel bar once weekly. The Resident Care Coordinator and Administrator will be responsible for continued compliance with this regulation.

Maintain documentation of audits for Department review. 1/2/20 MJ

Legal Entity Representative

Signature: Ellen Shrager | Printed Name and Title: ELLEN SHRAGER, EXECUTIVE DIRECTOR | Date: 7/16/19

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MJ (Initials)

- Fully Implemented
- X Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

183d - Prescription Current

Regulations

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

On 06/11/19, Ibuprofen Tab 600 MG prescribed for resident #4, was in the home's Medication Cart A, however, the medication was to be discontinued after 05/20/19.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

All discontinued medications will be removed from the medication cart when the prescriber discontinues the medication. The Nurse responsible for taking the order for the medication to be discontinued will be responsible for removing the medication from the medication cart and discarding it. When the shift to shift report is given the oncoming Nurse will verify that the discontinued medication has been removed and witness the discarding if the medication is a controlled substance. The night shift nurse will also verify that the medication was removed from the medication cart when she/he completes the 24 hour chart check and notes the discontinued order. The Resident Care Coordinator will do a medication cart audit monthly and will be responsible for continued compliance of ensuring that medications that are currently on the EMAR are available for administration and any discontinued medications were removed.

Immediately- A designee qualified to administer medications will complete an initial audit of the medication carts, first aid kits and any other medication storage areas to ensure there are no expired or discontinued medications. Any expired or discontinued medications will be immediately discarded in accordance with the Department of Environmental Protection and Federal and State regulations. All staff qualified to administer medication will be educated on the home's policy and procedures for safe management and disposal of prescription medications, OTC medications and CAM which are expired or discontinued. Maintain documentation of audits for Department reveiw. 1/2/20 MJ

Legal Entity Representative

Ellen Shroger — ELLEN SHROGER, EXECUTIVE DIRECTOR — 7/16/19

Signature | Printed Name and Title | Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

Fully Implemented
X Partially Implemented - Adequate Progress
Partially Implemented - Inadequate Progress
Not Implemented

The above plan of correction was approved by MJ (Initials)

185a - Implement Storage Procedures

Regulations

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 06/07/19, resident #5's blood glucose level was recorded as 276; however, the resident's glucometer read 239.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Nurses were reminded of the importance of accurately documenting glucometer readings. All glucometer readings will be verified for accuracy against the EMAR at shift change with the oncoming Nurse. The Resident Care Coordinator will check the glucometer and EMAR documentation periodically. Continued compliance will be the responsibility of the Resident Care Coordinator and the Administrator.

Immediately- Administrator or designee qualified to administered medications will complete a audit of all glucometers and MAR's to ensure readings are accurately documented. All staff qualified to administer medications will be educated on the importance of accurate glucometer reading documentation. Audits and education will be maintained for Department review. 1/2/20 MJ

Legal Entity Representative

[signature] Signature — ELLEN SHRAGER, EXECUTIVE DIRECTOR Printed Name and Title — 7/16/19 Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

The above plan of correction was approved by MJ (Initials)

Fully Implemented

Partially Implemented - Adequate Progress

X Partially Implemented - Inadequate Progress

Not Implemented

187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #5 is prescribed NovoLOG 100 Unit/ML based on a sliding scale. On 06/07/19, resident #5's blood glucose level was recorded as 276; however, the resident's glucometer read 239. This resulted in the resident being administered 6 units of NovoLOG instead of 4 units based on the correct reading from the glucometer.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

Nurses were reminded of the importance of following the prescriber's instructions. Nurses were also reminded about the importance of accurately documenting glucometer readings and the important part it plays in ensuring prescribed medications get administered according to the blood glucose readings and physician's orders. Continued compliance will be the responsibility of the Resident Care Coordinator.

Immediately- Administrator or designee qualified to administer medications will complete a audit of all glucometers and MAR's to ensure readings are accurately documented. All staff qualified to administer medications will be re-educated on administering medication including following the orders of the prescriber, and the proper administration and documentation of insulin administration. Audits and education will be maintained for Department review. 1/2/20 MG

Legal Entity Representative

[signature]	ELLEN SHRAGER, EXECUTIVE DIRECTOR	7/6/19
Signature	Printed Name and Title	Date

DEPARTMENT USE ONLY - HOMES MAY NOT WRITE IN THIS BOX!

The above plan of correction is approved as of 1/2/20 (Date)

Plan of correction implementation status as of 1/2/20 (Date)

Fully Implemented

Partially Implemented - Adequate Progress

X Partially Implemented - Inadequate Progress

Not Implemented

The above plan of correction was approved by MG (Initials)

Violation Report

Facility Information

Name: *LUTHERAN COMMUNITY AT TELFORD*
License Number: *12672*
Address: *235 NORTH WASHINGTON STREET,, TELFORD, PA 18969*
County: *BUCKS*
Region: *SOUTHEAST*

Administrator

Name: *Malissa Stroble*
Phone: *2157239819*
Email: *mstroble@LCTELFORD.ORG*

Legal Entity

Name: *LUTHERAN COMMUNITY AT TELFORD*
Address: *12 LUTHERAN HOME DRIVE, TELFORD, PA, 18969*

Certificate(s) of Occupancy

Staffing Hours

Resident Support Staff:
Total Daily Staff: *98*
Waking Staff: *74*

Inspection

Type: *Partial*
BHA Docket #:
Notice: *Unannounced*
Reason: *Incident,Interim*

Inspection Dates and Department Representative

09/10/2019 - On-Site: Youn Hie Chung

09/11/2019 - On-Site: Youn Hie Chung

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125*
Residents Served: *76*

Secured Dementia Care Unit

In Home: *Yes*
Area: *Shepherd's Way*
Capacity: *26*
Residents Served: *21*

Hospice

Current Residents: *x*

Number of Residents Who:

Receive Supplemental Security Income: *0*
Are 60 Years of Age or Older: *76*
Diagnosed with Mental Illness: *26*
Diagnosed with Intellectual Disability: *0*
Have Mobility Need: *22*
Have Physical Disability: *2*

65a - FS Orientation 1st Day

Regulations

2600.

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:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff person A, whose first day of work was 02/07/2017, did not receive orientation on the topics listed above.

Plan of Correction (POC)

2600.65.a Staff person A completed all the initial orientation training and the training required to be completed within the first 40 hours. The document to verify that this information was completed, understood and the opportunity to ask questions is attached.

Human Resource personnel are in the process of reviewing each staff members record to verify that the required training has been completed within the required time period. If there is a staff member's record that does not contain the required documentation to reflect the training was completed that staff member will be required to attend the next facility orientation scheduled during their work shift.

To ensure future compliance, the procedure for the initial orientation training and the subsequent training requirements required within the first 40 hours have been reviewed and changed. The new training procedure ensures all required topics are covered for all staff members hired during the facility training day, which is prior to the first day of work. Human Resource personnel will be responsible to ensure future compliance with this regulation.

Legal Entity Representative Within 30 days receipt of this plan of correction- All staff persons involved in the hiring and retention of staff will be educated on the home's polivy and procedures for new staff person training. Documentation will be kept. 1/2/20 MC

Ellen Shrager — Signature | ELLEN SHRAGER, EX. DIRECTOR — Printed Name and Title | 10/17/19 — Date

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Plan of correction implementation status as of 1/2/20 (Date)

- [ ] Fully Implemented
- [ ] Partially Implemented - Adequate Progress
- [x] Partially Implemented - Inadequate Progress
- [ ] Not Implemented

The above plan of correction was approved by MC (Initials)

65b - Rights/Abuse 40 Hours

Regulations

2600.

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

1. Resident rights
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.

Description of Violation

Staff person A, hired on 02/07/2017, has no record of training in the topics listed above.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.65.b Staff person A completed all the initial orientation training and the training required to be completed within the first 40 hours. The document to verify that this information was completed, understood and the opportunity to ask questions is attached.

Human Resource personnel are in the process of reviewing each staff members record to verify that the required training has been completed within the required time period. If there is a staff member's record that does not contain the required documentation to reflect the training was completed that staff member will be required to attend the next facility orientation scheduled during their work shift.

To ensure future compliance, the procedure for the initial orientation training and the subsequent training requirements required within the first 40 hours have been reviewed and changed. The new training procedure ensures all required topics are covered for all staff members hired during the facility training day, which is prior to the first day of work. Human Resource personnel will be responsible to ensure future compliance with this regulation.

Immediately- All staff persons involved in the hiring and retention of staff will be educated on the home's policy and procedures for new staff person training including the requirements. Documentation of education will be kept. 1/2/20 MJ

Legal Entity Representative

Ellen Shrager | ELLEN SHRAGER, EX. DIRECTOR | 10/17/19

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65c - Ancillary Staff Orientation

Regulations

2600.
65.c. 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

Ancillary staff person A, whose first day of work was 02/07/2017, did not have a general orientation to his specific job functions.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.65.c Staff person A reviewed and signed a job description outlining the requirements relating to his/her specific job functions. The document to verify that this information was completed, understood and the opportunity to ask questions is attached.
Human Resource personnel are in the process of reviewing each ancillary staff member's record to ensure that each employee has a document stating that they have had the opportunity to review the requirements outlined for their specific job functions prior to working in the capacity of that position. If there is a staff member's record that does not contain the required documentation to reflect the general orientation to the specific job function as it relates to the position they are working in, a general orientation will be completed and a document signed to verify that this information was completed, understood and the opportunity to ask questions was given.
To ensure future compliance, for ancillary staff members a general orientation to their specific job function as it relates to their position will be provided at the facility training day, which is prior to the first day of work.
Human Resource personnel will be responsible to ensure future compliance with this regulation.

Legal Entity Representative

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65g - Annual Training Content

Regulations

2600.

65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A has no record of training in the topics listed above for training year 2018.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.65.g Staff person A did not complete the required training topics listed for 2018. See the attached documentation that verifies this training has been completed for 2019.
Staff person A and his/her direct supervisor have been counseled on the importance of annual trainings on the required topics for all Personal Care staff members. There is a plan in place to ensure all staff members training records are reviewed periodically by their department supervisor to verify the required trainings are completed by the end of the calendar year. Within 30 days of receipt of this plan of correction: The administrator or designee will review all current staff training and records to ensure all direct care staff have received the required training on all topics during the training year. 1/2/20 [initials]

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[signature] ELLEN SHRAGER, EX. DIRECTOR 10/17/19

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185a - Implement Storage Procedures

Regulations

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

Resident #2 is prescribed Accuchecks 3 times daily before meals. For 09/04/2019 at 11:56 AM, his glucometer reads 266 while MAR shows 226. For 09/03/2019 at 11:59 AM, his glucometer reads 139 while MAR shows 131.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.185.a Nurses were reminded of the importance of accurately documenting glucometer readings. A sign was placed on all medication carts to alert Nurses and agency Nurses of the importance of checking glucometer results against the EMAR. All glucometer readings will be verified for accuracy against the EMAR at shift change with the oncoming Nurse. The Resident Care Coordinator will check the glucometer and EMAR documentation periodically. Continued compliance will be the responsibility of the Resident Care Coordinator and the administrator.
Immediately- Administrator or designee qualified to administer medications will complete a audit of all glucometers and MAR's to ensure readings are accurately documented. All staff qualified to administer medications will be educated on the importance of accurate glucometer reading documentation. Audits and education will be maintained for Department reveiw. 1/2/20 MC

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Ellen Shrager — Signature
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10/17/19 — Date

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187a - Medication Record

Regulations

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:

5. Dosage form
6. Dose.
7. Route of administration.
8. Frequency of administration.

Description of Violation

The pharmacy label for resident #1s Ilevro Drop 0.3% does not match his MAR. Its label says 'one drop right eye once daily' while his MAR reads 'one drop right eye once daily for 33 days.'

The pharmacy label for resident #1's Prednisolone Sus 1% Op says '1 drop right eye 4 times a day' while his MAR reads '1 drop right eye three times a day for 7 days.'

The label for resident #1's Albuterol Neb Sol says '1 vial via nebulizer 4 times daily as needed' while his MAR reads '1 vial via nebulizer every 4 hours as needed.'

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.187.a Nurses were reminded of the importance of checking the EMAR and the pharmacy label of the medication they are administering to ensure they match. If there is a discrepancy the Nurses were instructed to verify the medication administration directions with the most current physician orders and apply a direction change label until a new label or medication supply becomes available. The 11-7 shift Nurse is responsible to audit the medication cart and ensure all ordered medications are available to administer.

Immediately: A staff person qualified to administer medications will conduct an initial and monthly review of all current resident MARs and prescriber's orders to ensure all prescribed medications are documented on the resident's MAR's.
1/2/20 MJ

Legal Entity Representative

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187b - Date/Time of Medication Admin.

Regulations

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

Description of Violation

Resident #3's medication administration record does not include the initials of the staff person who administered Gabapentin 300 mg, Gas Relief 80 mg, Duloxetine 20 mg, Omeprazole 40 mg, and Diltiazem 60 mg on 06/25/2019 at bedtime.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.)

2600.187.b Nurses have been instructed to run a compliance report from the EMAR at the end of their shift to ensure all ordered medications and treatments have been administered and documented accordingly. The Nurses are responsible for ensuring this report is completed and the Resident Care Coordinator is responsible for ensuring the compliance report reflects no medication or documentation errors.

Within 30 days of receipt of this plan of correction: All staff persons qualified to administer medications will be re-educated on the proper procedures for medication administration including documentation of medication administration at the time of administration in accordance with regulation 2600.187(b). Documentation of education and audits shall be kept for Department review. 1/2/20 MJ

Legal Entity Representative

[signature] ELLEN SHRAGER, EX. DIRECTOR 10/17/19
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187d - Follow Prescriber's Orders

Regulations

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 is prescribed Humalog 100 Unit on a sliding scale. On 09/04/2019 at 11:56am, his glucometer reads 266 while the MAR shows 226, which resulted in the wrong dosage of insulin injections (3 units instead of 4 units).

Resident #3 is prescribed Hydrocodone/A-PAP 5-325 mg two times daily. She was not given this medication at bedtime on 06/25/2019 (it was not signed out on the Narcotic sign-out sheet).

Resident #4 was prescribed Vascepa 1 GM once daily starting 08/18/2019. He was given this medication twice daily on 08/18/19 through 09/04/19. The home found out about this error when the med ran out and was reordered too early.

Plan of Correction (POC)

2600.187.d Resident #3 and Resident #4 were medication errors that were reported to the department when the errors were discovered. The proper reporting protocol was followed. The Nurse responsible for the medication error for Resident #3 was an agency nurse. The agency was notified of the error and requested that the Nurse be reminded about the importance of following physician orders. The Nurse responsible for the medication error for Resident #4 was counseled and reminded about the 6 rights of medication administration and the importance of following physicians orders.
Resident #2 medication error resulted from a documentation error by an Agency nurse. The agency was contacted and informed of the error. It was requested that the Nurse be reminded about the importance of following physician orders and ensuring that the documentation in the EMAR matches the reading in the glucometer. A sign was placed on all medication carts to alert Nurses and agency Nurses of the importance of checking glucometer results against the EMAR. Personal Care Nurses were reminded of the importance of following the prescriber's instructions. Nurses were also reminded about the importance of accurately documenting glucometer readings and the important part it plays in ensuring prescribed medications get administered according to the blood glucose readings and the physician's orders. Continued compliance will be the responsibility of the Resident Care Coordinator. See attached MC

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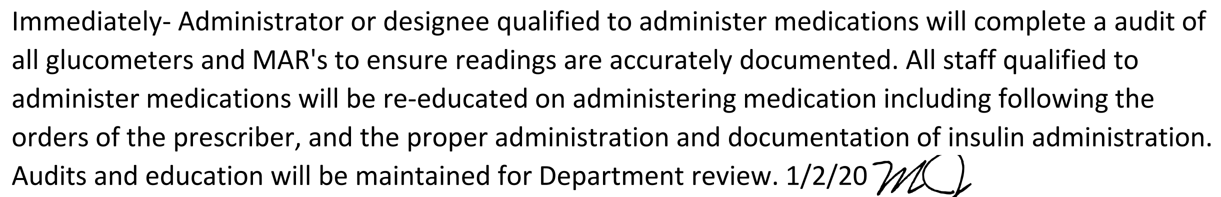
2600.187d 9a



Immediately- Administrator or designee qualified to administer medications will complete a audit of all glucometers and MAR's to ensure readings are accurately documented. All staff qualified to administer medications will be re-educated on administering medication including following the orders of the prescriber, and the proper administration and documentation of insulin administration. Audits and education will be maintained for Department review. 1/2/20

252 - Record Content

Regulations

2600.
252. Content of Resident Records - Each resident's record must include the following information:
10. A record of incident reports for the individual resident.

Description of Violation

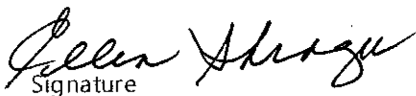
Resident #5's record does not include a record of incident reports.

Plan of Correction (POC)

(Attach pages as necessary. Remember that you must sign and date any attached pages. Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the stebs will be completed.)

2600.252 All resident records were reviewed and compared with the incident report binder. Any missing incident reports were copied and placed in the resident's individual record.
To ensure continued compliance, a copy of each incident report will be made. This copy will become part of the resident's individual record and the original will remain in the incident report binder to be logged and tracked. The Administrator is responsible for continued compliance.

Legal Entity Representative



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