Department of Human Services
Bureau of Human Service Licensing

January 14, 2022

[redacted]
12 LUTHERAN HOME DRIVE
TELFORD, PA, 18969

RE: LUTHERAN COMMUNITY AT TELFORD
235 NORTH WASHINGTON STREET
TELFORD, PA, 18969
LICENSE/COC#: 12672

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing licensing inspections on 11/23/2021 of the above facility, the citations specified on the enclosed Licensing Inspection Summary (LIS) were found.

We have determined that your plan of correction is: Acceptable

All citations specified on the plan of correction must be corrected by the dates specified on the License Inspection Summary (violation report) and continued compliance with Department statutes and regulations must be maintained.

Sincerely,
Mia Johnson

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

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

Facility Information

Name: *LUTHERAN COMMUNITY AT TELFORD* **License #:** *12672* **License Expiration:** *08/02/2022*

Address: *235 NORTH WASHINGTON STREET, TELFORD, PA 18969*

County: *BUCKS* **Region:** *SOUTHEAST*

Administrator

Name: [redacted] **Phone:** *2157239819* **Email:** [redacted]

Legal Entity

Name: *LUTHERAN COMMUNITY AT TELFORD*

Address: *12 LUTHERAN HOME DRIVE, TELFORD, PA, 18969*

Phone: *2157239819* **Email:** [redacted]

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:** *96* **Waking Staff:** *72*

Inspection Information

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

Reason: *Incident* **Exit Conference Date:** *11/23/2021*

Inspection Dates and Department Representative

11/23/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served:** *74*

Secured Dementia Care Unit

In Home: *Yes* **Area:** *Shepards Way* **Capacity:** *26* **Residents Served:** *22*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older:** *74*

Diagnosed with Mental Illness: *11* **Diagnosed with Intellectual Disability:** *0*

Have Mobility Need: *22* **Have Physical Disability:** *2*

Inspections / Reviews

11/23/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *12/26/2021*

01/14/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *01/17/2022*

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On [redacted], at 9:30 AM, resident #1 had an unwitnessed fall in [redacted] room. The resident was sent to the hospital with a suspected broken rib which was later confirmed. The home did not report this incident to the Department until 11/15/21.

Plan of Correction ***Accept***

Resident #1 resides in our secured dementia unit. While the nurse supervisor was assessing Resident #1 following the unwitnessed fall sustained on Saturday, [redacted] Resident #1 stated that [redacted] felt like [redacted] had broken a rib. The 7-3 nurse supervisor sent the resident to the ER for evaluation via ambulance. On [redacted] the 3-11 nurse supervisor called the hospital for a status update on Resident #1. There had been no previous conversation from the hospital to the facility regarding the resident's status. The hospital stated that the resident would be admitted for hypoxia and a fall. Resident #1 was discharged from the hospital on [redacted] to our HCP with a new order for oxygen. On Monday, 11/15/21 the Resident Care Coordinator was reviewing the nursing information from the weekend and the hospital portal regarding Resident #1 and noted that in the hospital notes it was revealed that Resident #1 sustained a rib fracture. As soon as the Resident Care Coordinator read the hospital information on their portal indicating a fracture the incident and injury was reported to the department. There was no communication from the hospital to the Personal Care team that indicated a fracture at any time. I respectfully disagree that there was a delay in reporting the fracture as it was reported as soon as the PC team was made aware of the fracture. The suspicion of the fracture came from the resident and not a clinical professional dictating a diagnosis and treatment.

To ensure the facility remains in compliance should this situation ever occur again, an email was sent to all nurses on Monday 12/20/21 regarding transferring a resident to the hospital. This email encourages the nurses when receiving a status report from the hospital to please document the date/time and who they spoke with. In addition, if the resident was sent for a fall to ask if the resident received any treatment for lacerations including but not limited to staples, sutures or glue treatment and if there is any possibility that the resident may have sustained a fracture of any sort. If the hospital responds yes to any of the questions a incident report will need to be sent to the department.

Completion Date: *12/20/2021*