

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

August 8, 2024

[REDACTED], ADMINISTRATOR  
LUTHERAN COMMUNITY AT TELFORD  
[REDACTED]  
[REDACTED]

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 review on 05/22/2024 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: LUTHERAN COMMUNITY AT TELFORD License #: 12672 License Expiration: 08/02/2024  
Address: 235 NORTH WASHINGTON STREET, TELFORD, PA 18969  
County: BUCKS Region: SOUTHEAST

**Administrator**

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

**Legal Entity**

Name: LUTHERAN COMMUNITY AT TELFORD  
Address: [REDACTED]

**Certificate(s) of Occupancy**

Type: 1 2 Date: 08/06/2012 Issued By: Borough of Telford

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 98 Waking Staff: 74

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
Reason: Complaint, Incident Exit Conference Date: 05/22/2024

**Inspection Dates and Department Representative**

05/22/2024 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:	Shepherd's Way
Capacity:	26	Residents Served:	23
Hospice			
Current Residents:	3		
Number of Residents Who:			
Receive Supplemental Security Income:	0	Are 60 Years of Age or Older:	74
Diagnosed with Mental Illness:	20	Diagnosed with Intellectual Disability:	0
Have Mobility Need:	24	Have Physical Disability:	8

**Inspections / Reviews**

05/22/2024 - Partial  
Lead Inspector: [REDACTED] Follow Up Type: POC Submission Follow Up Date: 06/24/2024

Inspections / Reviews *(continued)*

07/24/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 08/05/2024

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 08/16/2024

08/08/2024 Document Submission

Submitted By: [REDACTED]

Date Submitted: 08/05/2024

Reviewer: [REDACTED]

Follow Up Type: Not Required

## 42b - Abuse

**1. Requirements**

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

**Description of Violation**

*Resident 1's file contains a preadmission screening dated [REDACTED], indicating a history of problematic behavior, including physical violence towards others and occasionally grabbing their spouse's arm due to agitation. Resident 1's current support plan, dated [REDACTED], notes previous episodes where Resident 1 did not recognize their spouse and demanded that they leave, perceiving them as an intruder. Resident 1 has shown increased resistance to assistance with care, requiring frequent redirection and exhibiting multiple episodes of agitation and physical aggression towards residents and staff members in memory care.*

*On [REDACTED], Resident 1 grabbed a CNA's wrist, slammed them into the wall, blocked the door, and raised their hands as if to hit the CNA.*

*On [REDACTED], Resident 1 pushed another resident onto the floor.*

*On [REDACTED] Resident 1 repeatedly smacked a CNA on their buttock.*

*On [REDACTED], Resident 1 became verbally and physically aggressive towards their spouse, who was visiting and was not allowing them to leave his room. Resident 1 was yelling and pushing their spouse down into a recliner chair.*

*On [REDACTED], Resident 1 became agitated when two residents entered their room. Resident 1 did not touch the residents but yelled, "Get out of my room!" As staff redirected the other residents, Resident 1 aggressively attempted to grab a CNA's leg, held their right arm, and tried to twist it.*

*On [REDACTED], Resident 1 was observed gripping both of another resident's hands in the living room, causing a small injury to the other resident.*

*On [REDACTED], Resident 1 slapped a CNA who was attempting to provide care. On 4/12/24, Resident 1 was angry and attempted to kick the staff who was assisting with care.*

*On [REDACTED], Resident 1 refused to take a shower, smacked staff on the buttocks, called staff names, and was argumentative to others.*

*Resident 1 and Resident 2 shared a suite in memory care. Resident 2 often went to Resident 1's side of the room and touched their belongings, which easily agitated Resident 1. On [REDACTED], at around [REDACTED], Resident 1 sought help from a CNA. The CNA found Resident 2 on the floor of Room [REDACTED] lying on their back, and yelling for help. The CNA alerted an LPN, who assessed Resident 2. Resident 2 sustained serious injuries and was transported to the local hospital. When the LPN asked what happened, Resident 1 stated, "They did not belong in here, so I punched them in the face and pushed them."*

*Prior to the incident on [REDACTED], Resident 1 had displayed multiple aggressive behaviors towards other residents and staff members. However, the home was dismissive about Resident 1's behavior, neglecting to implement other positive interventions and safe management techniques and neglected Resident 2's safety by having them share a room.*

42b Abuse (continued)

Plan of Correction

Accept [redacted] - 07/24/2024)

Resident 1 had displayed multiple behaviors with the care team when providing care. Frequently residents with dementia exhibit behaviors surrounding care because of their cognitive decline and inability to understand the need for care or instructions. The care team recognized the pattern of behaviors with Resident 1 and [redacted] care, and implemented some subtle changes such as a slow approach an example is when waking Resident 1 up in the morning, the aide would remind Resident 1 that [redacted] breakfast and medications will be provided by the nurse shortly. The nurse would then come in with [redacted] medication and breakfast and then a while later the aide would come in to offer assistance with dressing and care. This simple intervention allowed Resident 1 additional time to wake up without the presence of a care giver or nurse and allowing Resident 1 to attempt the task prior to staff assistance. This plan did not remove the behaviors entirely, but it did lessen the amount of behaviors around morning care with Resident 1.

Resident 1 began demonstrating behaviors that were noted by the nurses to be indicative of a possible infection Resident 1 was tested and diagnosed with a urinary tract infection and treated accordingly.

On another occasion it was determined that Resident 1 could have been suffering from adverse effects from a newly started medication and that caused some behaviors. The medication was discontinued.

Lutheran Community at Telford did not change Resident 1's room to a private room as it was determined that Resident 1's behaviors were a result of an infection, the staff utilized alternate ways for Resident 1 to be accepting of care and an adverse effect of a medication. Prior to this incident Resident 1 had not displayed any aggression toward Resident 2.

The Lutheran Community at Telford will be forming an interdisciplinary team that will meet to discuss any negative behaviors demonstrated by any resident of the community. Each incident will be evaluated on a case to case basis. A plan will be put into place dependent upon the situation and behavior exhibited by the resident. This plan could include interventions such as a room change, a consult with a psychologist/psychologist, implementation of a 1:1 with an outside provider, an inpatient stay at a psychiatric facility or if warranted a 30 day notice with assistance in placement at a facility more equipped to meet the resident's needs. The resident's family and primary care physician will be part of the conversation, treatment and plan for the resident. The Resident Care Coordinator in conjunction with the staff nurses will be responsible for monitoring the behaviors of the residents in Personal Care and our secured dementia unit and reporting any behaviors to the Administrator and the interdisciplinary team for further follow up

Licensee's Proposed Overall Completion Date: 08/15/2024

Implemented ([redacted] - 08/06/2024)

225c - Additional Assessment

3. Requirements

2600.

225.c. The resident shall have additional assessments as follows:

- 1. Annually.
- 2. If the condition of the resident significantly changes prior to the annual assessment.
- 3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Residents current assessment dated [redacted] indicates resident has a minimal need relating to aggression. On [redacted] Resident 1 displayed physical aggression toward another resident by pushing them to the ground. The home did not complete an assessment with an update to residents behavioral needs related to aggression.

225c - Additional Assessment (continued)

**Plan of Correction**

**Accept** [redacted] - 07/24/2024)

The assessment dated [redacted] was the initial assessment for Resident 1 to be admitted to our secured dementia unit. An update to the assessment was not completed for the physical aggression that Resident 1 demonstrated on [redacted] although it was noted in the resident's digital chart. Resident was seen by his PCP's CRNP and his Psychiatric CRNP on [redacted]. On [redacted] new orders were received for medication adjustments to treat Resident 1's behavioral and psychological symptoms of [redacted]. There have been other updates to Resident 1's assessment for the other incidents of aggression following the 2/5/24 incident. The 2/5/24 incident update was missed on the assessment. The Resident Care Coordinator is doing an audit of all secured dementia resident's charts to ensure their assessment accurately reflects the resident's needs regarding aggression.

If there is an instance of aggression noted with a resident going forward the Resident Care Coordinator will update the resident's assessment to reflect the amount of aggression the resident exhibited.

Resident 1 is no longer a resident at LCT therefore a revision to Resident 1's assessment has not been completed.

**Licensee's Proposed Overall Completion Date: 07/03/2024**

**Implemented** [redacted] - 08/06/2024)