

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

January 14, 2025

[REDACTED]
LUTHERAN COMMUNITY AT TELFORD
[REDACTED]

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

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 09/04/2024, 09/05/2024 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:** 08/02/2025
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]
Phone: [REDACTED] **Email:** [REDACTED]

Certificate(s) of Occupancy

Type: 1 2 **Date:** 08/06/2021 **Issued By:** L&I

Staffing Hours

Resident Support Staff: 0 **Total Daily Staff:** 100 **Waking Staff:** 75

Inspection Information

Type: Full **Notice:** Unannounced **BHA Docket #:**
Reason: Renewal **Exit Conference Date:** 09/05/2024

Inspection Dates and Department Representative

09/04/2024 On Site: [REDACTED]
09/05/2024 On Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 125 **Residents Served:** 77

Secured Dementia Care Unit

In Home: Yes **Area:** Shephards' Way **Capacity:** 26 **Residents Served:** 20

Hospice

Current Residents: 4

Number of Residents Who:

Receive Supplemental Security Income: 0 **Are 60 Years of Age or Older:** 77
Diagnosed with Mental Illness: 20 **Diagnosed with Intellectual Disability:** 0
Have Mobility Need: 23 **Have Physical Disability:** 8

Inspections / Reviews

09/04/2024 - Full

Lead Inspector: [REDACTED] **Follow Up Type:** POC Submission **Follow Up Date:** 09/26/2024

Inspections / Reviews (*continued*)

09/30/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2025

Reviewer: [REDACTED]

Follow Up Type: POC Submission

Follow Up Date: 10/05/2024

10/04/2024 POC Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2025

Reviewer: [REDACTED]

Follow Up Type: Document Submission Follow Up Date: 11/06/2024

01/14/2025 Document Submission

Submitted By: [REDACTED]

Date Submitted: 01/13/2025

Reviewer: [REDACTED]

Follow Up Type: Not Required

65a FS Orientation 1st Day

1. Requirements

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 [REDACTED], did not receive orientation on the topics listed above until [REDACTED].

Plan of Correction

Accept ([REDACTED] - 10/04/2024)

A review of our Orientation program was completed and determined that the documentation of the initial day orientation was completed on day 2 of orientation but prior to the employee shadowing on the unit. The orientation program was revised to complete and document the mandatory trainings on day 1 of orientation instead of day 2 of orientation. The department head to each department is responsible for completing the orientation and ensuring accuracy and the HR department will do periodic checks to monitor compliance. Periodic checks will include monthly, random, and ongoing reviews of the new employee documentation forms from varied departments for completeness, accuracy and compliance. The periodic checks by HR will start in October and be done by the Director of Human Resources or their designee.

Proposed Overall Completion Date: 10/04/2024

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented ([REDACTED] - 01/14/2025)

65g Annual Training Content

2. Requirements

2600.

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

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).

Description of Violation

Staff person B did not receive training in the topics listed above during training year 2023.

Plan of Correction

Directed ([REDACTED] 10/04/2024)

A review was completed of the team's 2023 training. A review of the teams 2024 required annual training will be completed by 12/15/24. Staff was reminded of the importance of attending trainings, completing required trainings and ensuring the adequate amount of training hours have been completed annually. Staff person B will complete

65g Annual Training Content (continued)

the required training by 12/31/24 via RELIAS and the Fire Safety and Emergency Preparedness training will be completed on 10/17/24 with the fire safety expert. The department head to each department is responsible for monitoring their teams progress with training throughout the year. HR department will do periodic checks to ensure compliance by the end of the calendar year. The Director of Human Resources or their designee will complete periodic checks on quarterly basis beginning October 2024 for training to be completed within that quarter to ensure the required trainings are completed within the calendar year. This quarterly review will be completed for 1 year.

Proposed Overall Completion Date: 10/04/2024

Directed Plan of Correction:

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee shall review all staff training to ensure that all required topics for 2023 have been completed. The administrator shall ensure that any missed trainings are completed within 30 days of the receipt of the POC.

Within 30 days of the receipt of the acceptable plan of correction, the administrator shall ensure that staff person B receives training in the missed topics.

Within 10 days of the receipt of the acceptable plan of correction, the administrator or designee will review staff training records to review progress of required trainings for the current training year, and develop a plan to ensure that all required trainings are completed before the end of the training year.

Within 30 days of the receipt of the acceptable plan of correction, the administrator shall develop a process of reviewing staff training at least quarterly.

Directed Completion Date: 11/04/2024

Implemented [REDACTED] - 01/14/2025)

85a - Sanitary Conditions**3. Requirements**

2600.

85.a. Sanitary conditions shall be maintained.

Description of Violation

On [REDACTED] at 08:14 AM, staff C used resident [REDACTED] glucometer to check resident [REDACTED] blood sugar level.

Plan of Correction

Directed [REDACTED] - 10/04/2024)

The reportable incident was completed for this error on 8/12/24. The agency nurse responsible for the error was contacted by the administrator on 8/12/24 to educate on the importance of not sharing glucometers in a Personal Care setting. The agency nurse expressed understanding. Additional signage was added to the medication cart to remind the nurses that sharing of glucometers is not permitted and each resident has their own glucometer that must be used. The agency nurse has not returned to the facility as of today's date. All nursing staff will continue to do glucometer checks at the change of shift. The Resident Care Coordinator has ensured the signage is visible on all medication carts. As of today, 10/3/24, all glucometers are clearly labeled with the resident's name and room number. An inquiry will be made to see if agency nursing staff can receive information/training on our PC glucometer procedure prior to accepting a shift at our facility.

85a Sanitary Conditions (continued)

Proposed Overall Completion Date: 10/04/2024

Directed Plan of Correction:

Immediately, the administrator shall develop a process whereby agency staff receiving diabetic training, to include blood glucose monitoring and the use of glucometers prior to being assigned to perform tasks. The administrator shall review agency staff training of diabetes at least monthly for 6 months.

Directed Completion Date: 10/04/2024

Implemented [REDACTED] 01/14/2025)

96a - First Aid Kit

4. Requirements

2600.

96.a. The home shall have a first aid kit that includes nonporous disposable gloves, antiseptic, adhesive bandages, gauze pads, thermometer, adhesive tape, scissors, breathing shield, eye coverings and tweezers.

Description of Violation

The first aid kit in the 2nd floor wellness office does not include antiseptic.

Plan of Correction

Accept [REDACTED] - 10/04/2024)

One of the 3 first aide kits on the Personal Care unit did not have antiseptic in it. It was noted on the check sheet that the antiseptic expired in July and it was removed. The antiseptic has been replaced in the first aide kit. Upon investigation it was determined that the antiseptic was ordered and delivered but a breakdown in communication resulted in the antiseptic not being replaced in the first aide kit. The current process has been revised to include the CNA doing the monthly first aide check to notify not only the nurse but the purchaser when an item in any of the first aide kits need to be replaced. The notification needs to include the item, the kit it is needed for and the reason for the replacement (ie: used, expired, damaged, etc.). The 11 7 nurse will continue to be responsible for ensuring the monthly checks are completed and the new process for replacing any items is followed. Monthly checks of the first aide kits are standard procedure and have been part of the responsibility of the 11 7 team and will continue to be standard procedure indefinitely. The Administrator or designee will be responsible for periodic checks to ensure continued compliance.

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented [REDACTED] 01/14/2025)

103i - Outdated Food

5. Requirements

2600.

103.i. Outdated or spoiled food or dented cans may not be used.

Description of Violation

On [REDACTED] at 10:00 AM, there was an unlabeled, undated food item wrapped in aluminum foil in the freezer section of the stand alone refrigerator in the home's Secured Dementia Care Unit (SDCU).

Plan of Correction

Accept [REDACTED] - 10/04/2024)

The unlabeled, undated food item that was wrapped in aluminum foil in the freezer section of the refrigerator in

103i - Outdated Food (continued)

the Secured Dementia Care Unit was determined to be a staff members food item and removed at the time of inspection. The staff member was reminded of the importance of ensuring that any item that is placed in the refrigerator has a label on the item including the name of the item, name of the staff member the item belongs to and the date that the item was placed in the refrigerator. As part of their daily tasks, the dietary aides are responsible for checking the refrigerator/freezer in the areas that they are responsible for serving. This is a current responsibility and it is an ongoing task. The dining manager will be responsible for doing periodic checks to ensure compliance. The Administrator or designee will also complete sporadic spot checking of the refrigerator/freezer to ensure compliance is maintained. The sporadic spot checking by the administrator or designee will be done quarterly beginning October 2024.

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented [REDACTED] - 01/14/2025)

141a 1-10 Medical Evaluation Information

6. Requirements

2600.

141.a. A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission. The evaluation must include the following:

1. A general physical examination by a physician, physician's assistant or nurse practitioner.
2. Medical diagnosis including physical or mental disabilities of the resident, if any.
3. Medical information pertinent to diagnosis and treatment in case of an emergency.
4. Special health or dietary needs of the resident.
5. Allergies.
6. Immunization history.
7. Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
8. Body positioning and movement stimulation for residents, if appropriate.
9. Health status.
10. Mobility assessment, updated annually or at the Department's request.

Description of Violation

Resident [REDACTED] medical evaluation dated [REDACTED] did not include (9) Health Status/Cognitive functioning.

Plan of Correction

Accept [REDACTED] - 10/04/2024)

An audit of the resident's medical evaluations has been conducted. The process of ensuring the completeness of the medical evaluations has been reviewed. The current process allows for the gathering of information to be done by the Resident Care Coordinator and provided to the PCP/CRNP at the time of the resident's visit, The medical evaluations demographics is completed by the Resident Care Coordinator, when the medical evaluation is completed by the PCP/CRNP both the Resident Care Coordinator and the Administrator check the medical evaluation for completion. An additional step has been added to the current process to include the Resident Care Coordinator flagging the parts of the form that need to be completed by the PCP/CRNP at the time of the visit. The Resident Care Coordinator and the Administrator are responsible for ensuring continued compliance with the resident's medical evaluation being completed in its entirety. A review of each resident's medical evaluation prior to filing will be completed first by the Resident Care Coordinator when the medical evaluation is received from the CRNP/PCP. The Administrator will review the medical evaluation following the Resident Care Coordinator's review and prior to the medical evaluation being filed into the resident's chart. The Resident Care Coordinator and the Administrator will do a semi-annual audit of all resident's medical evaluations to ensure completion, accuracy and compliance with regulation 141a.

141a 1-10 Medical Evaluation Information (continued)

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented [redacted] - 01/14/2025)

185a - Implement Storage Procedures

7. Requirements

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 [redacted] at 10:41 AM, resident [redacted] glucometer was not calibrated to correct date. The glucometer displayed [redacted] 10:41 AM.

Plan of Correction

Accept [redacted] - 10/04/2024)

Resident [redacted] glucometer was calibrated to the correct date at the time of inspection. Glucometers on the unit were checked for accuracy - no additional errors discovered. Staff will be educated on ensuring the date/time for the glucometer is accurate at the time of the accucheck, at the time of documentation of the accucheck, and again at shift change when checking the glucometer and documented number in the MAR with the oncoming shift. The nurses will be responsible for ensuring the glucometers date/time are accurate. The Resident Care Coordinators will be responsible for checking the glucometers periodically to ensure the date/time and documentation are accurate and ensuring continued compliance. The nursing team was educated and reminded of the process and expectation of calibrating the resident's glucometers at our September nurse meeting on 9/16/24. This education was conducted by the Resident Care Coordinator. The information will be reiterated to the nursing team in an email from the Resident Care Coordinator to all nurses on 10/4/24. The Resident Care Coordinator will be responsible to do monthly audits of all glucometers beginning October 2024 for a period of 1 year.

Proposed Overall Completion Date: 10/04/2024

Licensee's Proposed Overall Completion Date: 10/04/2024

Implemented [redacted] - 01/14/2025)