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

May 8, 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 04/03/2025 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: *I 2* **Date**: *08/06/2021* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *95* **Waking Staff**: *71*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *04/03/2025*

Inspection Dates and Department Representative

04/03/2025 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *125* **Residents Served**: *75*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *Shepherd's Way* **Capacity**: *26* **Residents Served**: *18*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *75*

Diagnosed with Mental Illness: *17*

Diagnosed with Intellectual Disability: *1*

Have Mobility Need: *20*

Have Physical Disability: *9*

Inspections / Reviews

04/03/2025 - Partial

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *05/01/2025*

Inspections / Reviews *(continued)*

05/01/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *05/07/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *05/08/2025*

05/08/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *05/07/2025*

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

On [redacted] at 10:30 AM, Staff Person A observed Resident [redacted], rubbing the groin area of Resident [redacted] over top of the resident's clothing. Resident [redacted] was asleep in a reclining chair in the common area living room of the SDCU. Both residents reside in the SDCU. No other staff were present in the area at the time. A similar incident involving the same residents occurred on [redacted] and was investigated by the Department on [redacted]
The following behavioral concerns involving Resident [redacted] were documented by staff of the home, occurring between the incidents on [redacted] and [redacted]:
[redacted]: A staff person reported that Resident [redacted] made inappropriate sexual comments to another resident, stating, "Nice shoes, nice pants, and nice [redacted]" Although the resident to whom the comment was directed did not respond, other nearby residents expressed discomfort. Staff redirected the conversation and later discussed the inappropriate comments with resident [redacted]
[redacted] A staff person observed Resident [redacted] get up from a recliner in the living room and approach another resident who was seated. As the nurse entered the room, Resident [redacted] was seen attempting to touch the other resident's knee while saying, "That's nice, that's nice." Staff redirected Resident [redacted] back to their own chair and a staff person remained in the living room to monitor resident.
[redacted]: A staff person reported that, while escorting another resident into the living room after lunch, Resident [redacted] who was already seated, began repeatedly shouting at the resident, "Hey, hey, did you get any?" The other resident responded to resident [redacted] by stating "you're an asshole".
[redacted]: Following lunch, Resident [redacted] was heard making verbal comments to another resident about their clothing, stating, "Very nice, nice pants," while gesturing over the resident's body. A staff person intervened and redirected Resident [redacted] to another seat. Later, Resident [redacted] was seen motioning for the same resident to come and sit closer. The other resident did move to sit closer to Resident [redacted], who began caressing the leg of the other resident. Resident [redacted] was redirected.
After the incident on [redacted], staff of the home inquired with Resident [redacted] about their desire to be intimate with Resident 1. Resident [redacted] did not recall the interaction with Resident [redacted] stating ' I don't remember, I was asleep". Resident [redacted] further indicated that they did not want to be touched by Resident [redacted] in that manner.
In an interview conducted on [redacted] by the Department, Resident [redacted] confirmed not being in a romantic relationship with Resident [redacted] describing the relationship as a friendship. When asked if being touched or kissed by Resident [redacted] was acceptable, Resident [redacted] clearly responded, "No, we are just friends. I don't know how they think, but that's how I feel."
Staff interviews conducted on [redacted] also confirmed that the [redacted] incident occurred during a time when no supervision was present. While staff reported being aware of the monitoring needs and had procedures in place, they noted that the lack of 1:1 supervision made it difficult to provide constant oversight. Although the home was aware of prior behavioral concerns and a previous incident on [redacted], the safeguards in place were not sufficient to fully protect Resident [redacted] right to be free from unwanted sexual harassment or sexual contact.

Plan of Correction ***Accept [redacted] - 05/01/2025)***

Resident [redacted] and Resident [redacted] had a very friendly and cordial realationship and enjoyed eachother's company daily and their interactions were appropriate. Resident [redacted] had been and continued to be seen by medical professionals that deemed [redacted] placement in our secured dementia unit appropriate for [redacted] Resident [redacted] and the other residents in our secured dementia unit require regular supervision in the home for safety due to impared judgement and cognitive deficit. The facility filed appropriate and timely reports with the required agencies. The Administrator and

42b Abuse (continued)

Resident Care Coordinator reached out to AAA for guidance to ensure all necessary precautions were in place for Resident [redacted] safety with the first incident on [redacted]. AAA advised against 1:1 24 hour supervision at that time, as it could cause a dignity concern, irritability, and a steep financial burden on the family. The placement of furniture in the activitiy room was evaluated and changed to allow space between the chairs that Resident [redacted] and Resident [redacted] frequently chose. Resident [redacted] RASP was updated. Since [redacted], the staff have been observing and documenting on an audit sheet that the residents in the common area of our secured dementia unit are interacting appropriately every 30 minutes. This monitoring will continue for a period of 30 days. An all staff abuse training has been conducted by Bucks County AAA on [redacted] at our facility.
Previous to these incidents but after Resident #[redacted] admission to Lutheran Community at Telford, more indepth questions regarding past experiences/events have been added to our pre screening questions.
Since the time of this report Resident [redacted] has been discharged from our facility.

Licensee's Proposed Overall Completion Date: *04/28/2025*

Implemented [redacted] 05/08/2025)

236 - Staff Training

2. Requirements

2600.
236. Training - Each direct care staff person working in a secured dementia care unit shall have 6 hours of annual training related to dementia care and services, in addition to the 12 hours of annual training specified in § 2600.65 (relating to direct care staff person training and orientation).

Description of Violation

Direct care staff person A, who works in the Secure Dementia Care Unit (SDCU) received only 2.75 hours of dementia care training during the 2024 training year.

Plan of Correction ***Accept ([redacted] - 05/01/2025)***

A review of staff person A's 2024 training has been completed.
At the time of this report, staff person A has completed all required 2024 trainings and is up to date on assigned training topics for 2025 (see attached).
To ensure continued compliance, a quarterly review of all overdue staff trainings is conducted by the HR department and this information is provided to the department head to follow up with the employee. The department head will schedule time for the employee to complete the required trainings.

Licensee's Proposed Overall Completion Date: *04/28/2025*

Implemented [redacted] 05/08/2025)