

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395804	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Lutheran Community at Telford		STREET ADDRESS, CITY, STATE, ZIP CODE 12 Lutheran Home Drive Telford, PA 18969	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a resident was provided individualized care and services in regard to diagnostic testing and was not catheterized unless necessary for one of four sampled residents. (Resident 1)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Bladder Care/Foley Catheter Insertion, Removal/Obtaining Specimen, revealed that foley catheter insertion, maintenance, and removal were to be completed in accordance with current standards of care.</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included heart failure, anemia, malignant neoplasm of the prostate, and acute kidney failure. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was alert and oriented and was continent of bladder. A review of the care plan dated April 2, 2025, revealed that he was at risk for incontinence due to impaired mobility and that he was continent of bladder. There was an intervention to assist the resident to the toilet as needed and to ensure that he had an unobstructed path to the bathroom. Further review of nursing documentation dated April 4, 2025, revealed that the resident was alert and oriented and was able to independently ambulate to and from the bathroom. A review of the care plan dated April 7, 2025, revealed that Resident 1 had a fever of unknown origin. There was an intervention for staff to obtain a urine specimen for analysis to rule out a UTI.</p> <p>On April 7, 2025, a physician ordered for staff to obtain a urine specimen for analysis due to fever. On April 8, 2025, at 5:54 a.m., a registered nurse noted that the resident had been straight catheterized for the urine specimen. The nurse further noted that the urine was yellow with some sediment noted and that his bladder had emptied for almost 500 cubic centimeters (cc) of yellow urine. The nurse also noted that at the end of the output the resident had hematuria (blood in the urine). At 4:15 a.m., the resident rang the call bell because he had taken himself to the bathroom and staff had noted hematuria in the toilet.</p> <p>In an interview on May 13, 2025, at 12:30 p.m., the Director of Nursing stated that the nurse had collected the urine specimen via catheterization as per the policy; however, the resident was alert and oriented, able to make his needs known to staff, able to urinate on his own, and able to take himself to the bathroom.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility failed to ensure the resident was not catheterized unless necessary and failed to provide individualized care and services in order to obtain a urine specimen by means other than catheterization when the resident was able to voluntarily void.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		