STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395804	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Community at Telford	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure that a registered nurse (RN) maintained professional standards of quality in carrying out nursing care to promote and maintain the well-being of individuals as set forth in the Pennsylvania Code Title 49 Professional and Vocational standards for one of eleven sampled residents. (Resident 22)Findings include: Review of Pennsylvania Code Title 49, Chapter 21, State Board of Nursing, Subchapter A, Registered Nurses, revealed guidelines which included that an RN shall carry out actions which promote, maintain, and restore the well-being of individuals and follow appropriate standards of practice and professional codes of behavior to assure safe and effective practice. Review of the facility policy, titled Peripherally Inserted Central Catheter (PICC), last reviewed May 20, 2026, revealed that residents with PICC lines would have site care performed and the dressing changed one time per week and as needed for transparent clear dressings, and staff were to initial and date the new dressing at the time of dressing change. Clinical record review revealed that Resident 8 had diagnoses that included discitis (a painful inflammation and infection of the intervertebral disc space between the spinal bones) of the lumbar-sacral region of the spine and osteomyelitis (an infection of the bone). Resident 8 was readmitted to the facility on [DATE], after a hospitalization with a PICC line in place and orders for daily intravenous antibiotic treatments. On May 14, 2026, a physician ordered staff to give Resident 22 two grams of an antibiotic (cefepime hydrochloride) intravenously through the PICC line. On May 20, 2026, a physician ordered staff to change the PICC line dressing every Wednesday for infection prevention. Resident 22's task administration record for June, 2026, indicated that Registered Nurse (RN) 1 changed the PICC line dressing on the morning of Wednesday, June 17, 2026. Observations of Resident 8 on June 16, 2026, at 11:27 a.m., and 1:35 p.m., and on June 17, 2026, at 12:38 p.m., revealed that a PICC line was in place to the right upper arm and covered with a transparent dressing. No date or initials were observed on the dressing. In an interview on June 17, 2026, at 2:08 p.m., the Director of Nursing confirmed that the dressing should have been initialed and dated per the policy. 28 Pa. Code 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure a resident with pressure ulcers received necessary treatment and services for one of two sampled residents with wounds. (Resident 22)Findings include: Review of the facility policy entitled, Wound Care, last reviewed May 20, 2026, revealed that staff were to utilize preventative measures to avoid the development of pressure injuries unless the development was clinically unavoidable and necessary treatments and services were to be provided to promote healing and prevent infection and new injuries from developing. Clinical record review revealed that Resident 22 had diagnoses that included Alzheimer's disease, malnutrition, and diabetes. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident 22 had severe cognitive impairment, was incontinent, was dependent on assistance from staff for incontinence care and activities of daily living, and was at risk for developing pressure ulcers or injuries. Review of the care plan revealed the resident was at risk for pressure ulcer development related to immobility, peripheral vascular disease, and incontinence, had actual skin breakdown including a stage three pressure ulcer, and included an intervention for a licensed nurse to perform weekly skin evaluations. On May 18, 2026, staff documented that a small open area was identified on Resident 22's coccyx (tailbone) and left lower buttocks with unhealed moisture associated skin damage and an order was placed for wound care to evaluate Resident 22's wounds. Review of Resident 22's weekly skin assessments revealed no documented evidence the full body skin evaluation was completed on April 21, 2026, and May 21, 2026. In an interview on June 17, 2026, at 2:27 p.m., the Director of Nursing confirmed that staff did not perform the weekly skin inspections on Resident 22 on April 21, 2026, or May 21, 2026, and they should have. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, review of facility documentation, clinical record review, and staff interview, it was determined that the facility failed to implement safety precautions and develop interventions to prevent further falls for one of two sampled residents at risk for falls. (Resident 9) Findings include: Review of the facility policy entitled, Accidents and Incidents, last reviewed May 20, 2026, revealed that after a fall, vital signs were to be taken and recorded initially and every shift for 24 hours, the interdisciplinary team was to determine final interventions, and the care plan was to be updated. Clinical record review revealed that Resident 9 had diagnoses that included dorsalgia (back pain from muscles, nerves, or joints), dementia, history of falls, and restlessness and agitation. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and dependent on staff for activities of daily living. A review of facility documentation dated June 7, 2026, indicated that the resident had an unwitnessed fall in her room. After the fall, there was lack of evidence that staff continued to obtain vital signs every shift for 24 hours, as per facility policy. There was a lack of evidence that the interdisciplinary team had discussed and determined new interventions or that any additional measures were implemented following the fall to prevent a reoccurrence. A review of Resident 9's care plan revealed that the resident was at risk for falls and had previous falls, but did not indicate that an intervention was implemented after the resident's fall on June 7, 2026. In an interview on June 17, 2026, at 2:45 p.m., the Director of Nursing confirmed that there was no documented evidence that vital signs were obtained per policy and that the interdisciplinary team had discussed and developed interventions to prevent further falls, and that these things should have been done after Resident 9's fall on June 7, 2026. CFR 483.25(d)(1)(2) Accidents.Previously cited 11/21/2025 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.