STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at St Luke Village, The	1000 Stacie Drive Hazleton, PA 18201

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to implement a system to assure timely disposition of resident medications (the process of returning and/or destroying unused medications) to prevent loss and potential drug diversion. Finding include: Review of facility policy entitled, Disposal/Destruction of Expired or Discontinued Mediation, date revised [DATE], revealed that facility staff should destroy and dispose of medications in accordance with Facility policy and Applicable Law, and applicable environmental regulations. Facility should place all discontinued or outdated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. In Pennsylvania, discontinued and unused medications and medications of discharged or deceased residents shall be immediately removed from the medication cart and brought to nursing supervisory staff. Discontinued and unused medications shall be disposed of at least quarterly. Facility should dispose of discontinued medication, outdated medications, or medications left in Facility after a resident has been discharged in a timely fashion or no more than 90 days. During an observation of the facility's second floor medication room on [DATE], at approximately 9:05 AM accompanied by Employee 2 (Registered Nurse RN - Unit Manager) revealed resident medications stored in the drawers below the counter that included antibiotics, potassium, diabetes, anti-inflammatory, hypertension, pain, and diuretic medications. These medications were in bubbled, blister cards with a preprinted pharmacy label noting the medication, dosage, quantity, and resident names. Located on top of one of the stacks of blister cards, was a white, unlined, piece of paper, with a handwritten note that said all need to take turns as read by Employee 2 RN. A prelabeled bubbled, blister card of Macrobid, noted the dosage and amount of the medication, but lacked a resident's name, which appeared to have been scratched off the label as observed by Employee 2, RN. The label noted Macrobid (an antibiotic) 100 mg, give (illegible- written over) capsules (300 mg) by mouth 2 times a day for UTI for 3 days. Prep date [DATE]. Handwritten was *direction change* 100 mg BID. Located within the labeled bubbled, blister card were 11 capsules, as counted by Employee 2, RN, at that time. (continued on next page)

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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident CR3 had a physician order for Rifampin (an antibiotic medication) oral capsule 300 mg, give 1 capsule by mouth 2 times a day for joint infection right knee until [DATE], start date [DATE], and discontinued [DATE]. Resident CR3 was transferred to another skilled nursing facility on [DATE]. The resident's medications were located within the labeled bubbled, blister card were 8 capsules, as counted by Employee 2, RN when observed on [DATE]. Resident 5 had a physician order for glipizide (a diabetic medication) oral tablet 5 mg, give 2.5 mg by mouth in the evening related to diabetes, start date [DATE], discontinued [DATE], and observed remaining in the labeled bubbled, blister card were 12 tablets, as counted by Employee 2, RN, on [DATE]. Resident CR2 had a physician order for Linezolid (an antibiotic medication) oral tablet 600 mg, give 1 tablet by mouth 2 times a day for sepsis (a blood stream infection) for 14 days, start [DATE], the resident was discharged to home on [DATE]. The resident's remaining medication in the blister card were 4 tablets, as counted by Employee 2, RN, on [DATE]. Resident 18 had a physician order for Mobic (an anti-inflammatory medication) oral tablet 7.5 mg, give 1 tablet by mouth in the afternoon for shoulder pain for 5 days, start [DATE], and the resident's remaining medication in the bubbled, blister card was 1 tablet, as counted by Employee 2, RN, on [DATE]. Resident 69 had a physician order for Metolazone (a diuretic) oral tablet 5 mg, give 1 tablet by mouth in the morning related to essential hypertension for 5 days, start [DATE], and the 24 tablets remaining in the observed blister card, as counted by Employee 2, RN, on [DATE]. Resident 26 had a physician order for Metolazone (a diuretic) oral tablet 5 mg, give 5 mg by mouth 1 time a day for bilateral lower extremity (BLE) edema for 4 days, start date [DATE]. with one tablet remaining in the observed card when counted by Employee 2, RN, on [DATE]. Resident 52 had a physician order for Gabapentin (pain medication) oral capsule 100 mg, give 1 capsule by mouth 1 time a day for pain, take 2 capsules to equal 200 mg, start date [DATE], discontinued [DATE]. When observed on [DATE], in the med room the blister card contained 29 capsules, as counted by Employee 2, RN. Resident 44 had a physician order for Potassium Chloride ER (a medication to treat low potassium) oral tablet 20 MEQ, give 1 tablet by mouth one time a day for hypokalemia, start date [DATE], discontinued [DATE], with four tablets remaining in the med room in the card on [DATE]. During an interview with Employee 2, RN, on [DATE], at approximately 9:22 AM, she was unable to explain why the medications were stored in the drawer or explain the meaning of the handwritten note that stated all need to take turns on top of the discontinued medications. She further confirmed that these discontinued meds were not in a location designated for storage of medications awaiting final disposition. Employee 2 stated that when medications have been discontinued, changed, and or if a resident expires, the medications are to be inventoried, and placed in a pharmacy bag. She further stated that pharmacy deliveries to the facility occur daily so discontinued medications could possibly be returned to the facility daily. She also confirmed that nursing staff should have given these medications to the pharmacy for disposition and they should not remain in the facility in storage. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the facility's third floor medication room on [DATE], at approximately 9:28 AM accompanied by Employee 1 (Licensed Practical Nurse - LPN) medications were observed in drawer and cupboard below the counter, along with resident care equipment to include blood pressure cuff, medical machinery such as cardiac transmitters, paper tablets, dressings, laboratory test tubes, tape measures, pill crushers, markers, and pens. These medications were in boxes, and a plastic zip lock bag with preprinted pharmacy label noting the medication, dosage, quantity, and resident names. The medications in these drawers, and cabinet with resident names, included heparin vials (medication to treat blood clots), Paxlovid (medication to treat Covid), and Ipratropium - Albuterol solution (medication to treat wheezing). Resident CR1 had a physician order for Paxlovid (,d+[DATE]) oral tablet, give 1 tablet by mouth two times a day for COVID for 5 days, start date [DATE], and the resident expired [DATE]. Observation on [DATE], revealed 4 tablets were remaining in the box as counted by Employee 1, LPN. Resident 66 had a physician order for Heparin Sodium injection solution, 5000 unit/ml, inject 1 ml subcutaneously BID for deep vein thrombosis (DVT) prevention for 15 days. 1 ml (5,000 units), start date February 8, 2024. Observation on [DATE], revealed a labeled plastic zip lock bag containing 5 vials, as counted by Employee 1, LPN. Resident 71 had a physician order for Ipratropium - Albuterol solution 0.5 - 2.5 (3) MG/3 ML, take 3 ml inhale orally via nebulizer every 4 hours as needed for wheezing, start date [DATE]. Observation revealed 5 packets remaining in labeled box for a total 25 solutions, as counted by Employee 1, LPN, on [DATE]. During an interview with Employee 1, LPN, on [DATE], at approximately 9:40 AM, she was unable to explain why the discontinued resident medications were stored in the drawer and cabinet, among numerous supplies. She further confirmed that they were not stored in a location designated for discontinued medications awaiting final disposition or marked to identify the medications are discontinued and subject to destruction. Employee 1 stated that when medications are discontinued or changed, or if a resident expires, the medications are to be inventoried, and placed in a pharmacy bag. She further stated that pharmacy deliveries occur daily to the facility, and on occasion, multiple times a day. She also confirmed that nursing staff should have given these medications to the pharmacy for disposition and the medications should not remain in the facility in storage. During an interview with the Director of Nursing (DON) on [DATE], at approximately 10:20 AM, revealed that all the discontinued medications should be picked up by the pharmacy timely or destroyed by nursing staff, and not stockpiled in the nursing medication rooms. The DON confirmed that medications are to be in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction. During an interview with the Nursing Home Administrator (NHA) on [DATE], at approximately 11:22 AM, the NHA stated that the facility is to return the discontinued medications awaiting final disposition to the pharmacy, at a minimum 4 times a year (quarterly). However, the NHA unable to explain the medications belonging to Resident CR3, who had been discharged from the facility in [DATE]. She further confirmed the facility failed to implement procedures to promote the timely disposition of resident medications and security of medications awaiting final dispositions. 28 Pa Code 211.12 (d)(3)(5) Nursing services. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.9 (a)(1)(d)(j.1)(1)(2)(3)(4)(5)(k) Pharmacy services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39235 Based on observation and staff interviews it was determined that the facility failed to ensure the consistent implementation of infection control procedures designed to prevent the spread of infection in one out of two medication rooms (3 rd floor medication room). Findings include: Observation of the facility's third floor medication room on April 9, 2024, at approximately 9:28 AM accompanied by Employee 1 (Licensed Practical Nurse - LPN) revealed a small, dormitory size medication refrigerator located on the floor. Inside the refrigerator observations revealed resident medications were stored along with Observed two plastic, one-gallon containers of iced tea and on the door of the refrigerator were six {6}, 16 fluid oz. bottles of salad dressings. Interview with Employee 1, LPN, on April 9, 2024, at approximately 9:40 AM, confirmed that the food and beverages stored in the medication refrigerator belonged to staff. Interview with the Director of Nursing (DON) on April 9, 2024, at approximately 10:20 AM, confirmed the facility failed to store medication medications under sanitary conditions to prevent the potential spread of infection. 28 Pa. Code 211.10 (a)(d) Resident care policies 28 Pa. Code 211.12 (c)(d)(5) Nursing Services.