

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 10/16/2024
NAME OF PROVIDER OR SUPPLIER Pavilion at St Luke Village, The		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48276</p> <p>Based on observations and resident and staff interviews, it was determined the facility failed to provide services to maintain a clean and homelike environment for one of nine residents sampled (Resident 76).</p> <p>Findings include:</p> <p>During an interview on October 16, 2024, at 11:35 AM, Resident 76 indicated the facility is not taking her soiled clothing to the laundry. She explained there have been dirty clothes in the bottom of her closet, and this continues to occur.</p> <p>An observation on October 16, 2024, at 11:35 AM revealed Resident 76's closet had several dirty clothing articles crumpled up on the bottom shelf of her closet.</p> <p>During an interview on October 16, 2024, at 11:40 AM, Employee 1, Licensed Practical Nurse (LPN), indicated the facility washes Resident 76's clothing. She confirmed that worn, soiled, or dirty clothing should be placed in a laundry receptacle and sent to the laundry for cleaning. Employee 1, LPN, confirmed there was dirty clothing in Resident 76's closet and removed the dirty clothing.</p> <p>During an interview on October 16, 2024, at approximately 12:30 PM, the Nursing Home Administrator (NHA) confirmed the facility is responsible for providing services to maintain a clean and homelike environment for all residents.</p> <p>28 Pa. Code 201.18 (e)(1)(2.1) Management.</p> <p>28 Pa. Code 201.29 (a) Resident rights.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on clinical record review and resident interview, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure physician ordered medication, an antibiotic, was timely obtained and administered to treat cellulitis for one resident (Resident 75).</p> <p>Findings include:</p> <p>A review of the facility policy titled Notification of Change in Condition, last reviewed by the facility on May 9, 2024, revealed that the facility will promptly notify the resident, the attending physician, and the resident representative when there is a change in the resident's status or condition. The policy indicates the nurse will notify the attending physician and resident representative when there is a need to alter treatment significantly. Also, the policy states the nurse will contact the physician. In the event that the attending physician does not respond in a reasonable amount of time, the medical director may be contacted.</p> <p>A clinical record review revealed that Resident 75 was admitted to the facility on [DATE], with a diagnosis to include chronic atrial fibrillation (an abnormal heart rhythm).</p> <p>A progress note dated October 14, 2024, at 5:27 PM revealed Resident 75 was noted to have a slight pink discoloration on her right lower extremity.</p> <p>A physician's order dated October 14, 2024, indicated Doxycycline 100 mg by mouth twice a day for seven days for diagnosis of right leg cellulitis (a bacterial infection of the skin).</p> <p>A clinical record review revealed the pharmacy did not send the medication because the resident has a tetracycline medication allergy (an antibiotic medication allergy is a harmful reaction to an antibiotic). Doxycycline is contraindicated with a known tetracycline allergy.</p> <p>A progress note dated October 14, 2024, at 5:27 PM revealed a possible drug allergy with the medication Doxycycline 100 mg (an antibiotic medication).</p> <p>A progress note dated October 15, 2024, at 11:58 PM stated awaiting pharmacy and it is ok to start when received.</p> <p>A progress note dated for October 16, 2024, at 12:17 AM revealed the pharmacy did not send the Doxycycline 100 mg because the resident is allergic to the medication; the order must be clarified by the physician, and we are still waiting for a response.</p> <p>A progress note dated for October 16, 2024, at 10:55 AM indicated the pharmacy would not send medication due to residents' allergies and that the physician was notified.</p> <p>During an interview on October 16, 2024, at 11:25 AM, Resident 75 indicated that she still did not receive any doses of the Doxycycline 100 mg or other medication to treat her cellulitis identified on October 14, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on October 16, 2024, at 12:30 PM, the Nursing Home Administrator (NHA) indicated the physician did not respond to the facility's attempts to clarify and confirm the order for Doxycycline 100 mg. The NHA confirmed the facility failed to administer physician-ordered medication to Resident 75. Additionally, the NHA confirmed that nursing staff failed to implement provisions to contact the medical director to have the medication changed to prevent a delay in treatment.</p> <p>A clinical record review revealed, on October 16, 2024, at approximately 1:00 PM, Resident 75 did not receive the prescribed Doxycycline 100 mg or other medication to treat her cellulitis.</p> <p>28 Pa. Code 211.2 (d)(3) Medical director.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records, select facility policies, and staff interview, it was determined that the facility failed to ensure that the resident's drug regimen was free of unnecessary antibiotic drugs for one out of nine residents sampled (Resident 76).</p> <p>Findings included:</p> <p>A review of the facility policy titled Antibiotic Stewardship, last reviewed by the facility on May 9, 2024, revealed that antibiotics are to be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy states that staff orientation, training, and education will emphasize the importance of antibiotic stewardship and include how the inappropriate use of antibiotics affects individual residents and the overall community. The training and education will focus on the relationship between antibiotic use and gastrointestinal disease, opportunistic infections, medication interactions, and the evolution of drug-resistant pathogens.</p> <p>A clinical record review revealed that Resident 76 was admitted to the facility on [DATE], with diagnoses including idiopathic peripheral neuropathy (a condition in which nerve damage interferes with the functioning of the peripheral nervous system) and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 28, 2024, revealed that Resident 76 is cognitively intact, with a BIMS score of 14 (Brief Interview for Mental Status - a tool within the Cognitive Section of the MDS used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>A progress note dated August 18, 2024, at 5:27 PM, indicated that a urinalysis and culture and sensitivity urine sample (culture and sensitivity- A urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) was obtained and placed in the refrigerator for pickup in the morning.</p> <p>A progress note dated August 21, 2024, at 3:07 AM, indicated the culture was still pending.</p> <p>A urinalysis and culture report dated August 21, 2024, revealed that Resident 76's urine culture showed a growth of Escherichia coli (E. coli, a type of bacteria) greater than 100,000 CFU/ml.</p> <p>A communication fax dated August 22, 2024, revealed that Resident 76's criteria for antibiotic therapy were reviewed, and the criteria were not met. Antibiotic therapy was not started. However, the communication indicated that Resident 76's family insisted on antibiotic therapy, and Macrochantin 50 mg for five days was ordered by the physician.</p> <p>A physician's order for Resident 76, dated August 23, 2024, prescribed Macrochantin oral capsule 50 mg (Nitrofurantoin Macrocrystal), with directions to administer 50 mg by mouth three times a day for five days for a urinary tract infection.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A clinical record review revealed no documented evidence the resident had experienced any symptoms of a urinary tract infection, such as fever, chills, mental changes/confusion, fatigue, nausea/vomiting, pressure in the lower part of the pelvis, or increased urination, from August 18, 2024, through August 26, 2024.</p> <p>A Medication Administration Record for August 2024 revealed that Resident 76 was administered Macrochantin oral capsule 50 mg (Nitrofurantoin Macrocrystal) on August 23, 2024, at 9:00 AM, 1:00 PM, and 5:00 PM, and on August 26, 2024, at 9:00 PM.</p> <p>During an interview on October 16, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) confirmed that Resident 76 did not meet the criteria to justify treatment with antibiotic therapy (Macrochantin oral capsule 50 mg) on August 23, 2024, and August 26, 2024. The NHA confirmed that it is the facility's responsibility to ensure that residents' drug regimens are free of unnecessary antibiotics.</p> <p>28 Pa. Code 211.2 (d)(3) Medical director.</p> <p>28 Pa. Code 211.9 (k) Pharmacy services.</p> <p>28 Pa. Code 211.12 (d)(3) Nursing services.</p>		