

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 03/26/2025
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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a comprehensive review of clinical records, facility policies, and staff interviews, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the development of a pressure ulcer for one of 14 sampled residents (Resident CR 1), resulting in actual harm.</p> <p>Findings include:</p> <p>According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk.</p> <p>The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair.</p> <p>A review of facility policy titled Unavoidable Pressure Injury, last reviewed by the facility on June 6, 2024, revealed it is the facility's policy that a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's risk factors demonstrate they were unavoidable.</p> <p>A clinical record review revealed Resident CR 1 was admitted to the facility on [DATE], with diagnoses that included muscle weakness, dysphagia (difficulty swallowing) and urinary retention, with a foley catheter (a flexible tube inserted into the bladder to drain urine into a collection bag).</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 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident CR 1's admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 23, 2025, revealed that Resident CR 1 is cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is 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), and required substantial/maximal assistance for rolling in bed, required partial/moderate staff assistance for activities of daily living, required dependent total staff assistance for transfers, and was at-risk for the development of pressure ulcers and injuries.</p> <p>A review of Resident CR 1's plan of care initiated on January 17, 2025, revealed the resident was identified with skin impairments related to MASD (Moisture Associated Skin Damage). Planned interventions included providing a pressure-reducing mattress and wheelchair cushion, encouraging proper nutrition and hydration, conducting weekly skin assessments, and repositioning the resident every two hours. The goal was to maintain or achieve clean and intact skin. On February 15, 2025, the care plan was revised to address newly identified Stage II pressure ulcers on the buttocks and sacrum, with updated interventions including repositioning every hour and the use of positioning wedges. The revised goal was for the pressure injuries to show signs of healing with minimal risk of infection.</p> <p>A Braden Scale for Predicting Pressure Sore Risk form on admission dated January 17, 2025, identified Resident CR 1 as being at moderate risk for pressure injury development. Physician's orders dated January 17, 2025, included repositioning every two hours and the application of zinc cream each shift for MASD.</p> <p>A review of a facility skin assessment titled Weekly Skin Evaluation dated January 31, 2025, revealed the resident had existing skin issues that included MASD. No areas of pressure injury were noted on the weekly skin assessment.</p> <p>A review of an outside consultant wound report dated February 5, 2025, revealed no mention of any skin issues in the areas of the buttocks and sacrum.</p> <p>A review of a facility skin assessment titled Weekly Skin Evaluation dated February 7, 2025, revealed the resident had existing skin issues that included scar tissue on the buttocks and thighs. No areas of pressure injury were noted on the weekly skin assessment.</p> <p>A review of an outside consultant wound report dated February 12, 2025, revealed resident with IAD (Incontinence Associated Dermatitis) to the bilateral buttocks and sacrum. The right buttocks measured 1 cm in length, 1 cm in width, and 0.1 cm in depth; the left buttocks measured 3.5 cm in length, 2.5 cm in width, and 0.1 cm in depth; and the sacrum measured 2 cm in length, 2 cm in width, and 0.1 cm in depth. The wound base for the right buttocks, the left buttocks, and the sacrum all presented with granulation tissue (a type of new, temporary tissue that forms in response to an injury or wound). New treatment orders included cleansing the area with NSS (normal saline solution), apply medical-grade honey to the base of the wound, and secure with a bordered gauze twice a day and as needed.</p> <p>A review of a facility skin assessment titled Weekly Skin Evaluation dated February 14, 2025, revealed the resident had no mention of any skin issues in the areas of the buttocks and sacrum. No areas of pressure injury were noted on the weekly skin assessment.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility skin assessment titled Pressure Ulcer Wound Rounds dated February 15, 2025, revealed the resident had stage II pressure wounds and defined that as partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. The wounds assessed included the right buttock, which measured 1.5 cm in length, 1.5 cm in width, and 0.1 cm in depth; the left buttock, which measured 3.0 cm in length, 3.0 cm in width, and 0.1 cm in depth; and the sacrum, which measured 2.0 cm in length, 2.0 cm in width, and 0.1 cm in depth. All wounds were noted to have granulation tissue in the wound base.</p> <p>A review of a facility document titled Unavoidable Wound Documentation listed the resident had or was undergoing the following conditions as risk factors for developing pressure ulcers of malnutrition, weight loss, and refusal of treatments (as in hygiene, wound care, medications, and repositioning). Facility interventions noted in place prior to the development or worsening of pressure ulcers included turning and repositioning as indicated and that the resident took supplements as ordered. There was a discrepancy in the dates of this document, as one side was dated February 15, 2025, and the back side was dated January 17, 2025, before the resident had even acquired a pressure injury.</p> <p>An interview with the Director of Nursing (DON) on March 26, 2025, at approximately 1:45 PM revealed the document titled Unavoidable Wound Documentation should reflect February 17, 2025; however, it was not corrected on the document. The DON confirmed the facility was unable to provide evidence of weight loss or any refusal of treatments, and a review of physician's orders revealed an order for a Juven (nutritional supplement) one packet by mouth one time a day and increased to twice a day on February 21, 2025. The DON also confirmed the facility was unable to provide documented evidence of turning and repositioning every 2 hours as ordered by the physician from January 17, 2025, to February 15, 2025.</p> <p>A review of Resident CR 1's task summary reports (reports that capture care-related tasks completed by nurse aides) dated January 17 through February 15, 2025, failed to reveal that staff performed pressure ulcer prevention tasks of scheduled turning and repositioning to prevent the development of pressure areas.</p> <p>Resident CR 1's clinical record review failed to reveal that licensed nursing staff developed and implemented interventions for the prevention of the development of pressure areas related to the resident's declined mobility, to include turning and repositioning every 2 hours as ordered by the physician from January 17 through February 15, 2025.</p> <p>A review of a facility skin assessment titled Pressure Ulcer Wound Rounds dated February 19, 2025, revealed the resident had unstageable pressure wounds and defined that as full-thickness tissue loss in which the base of the ulcer is covered by slough (yellow/white material consisting of dead cells) or eschar (dead tissue) in the wound bed. The wounds assessed included the right buttock that measured 2.0 cm in length, 2.0 cm in width, and 0.1 cm in depth; the left buttock measured 2.5 cm in length, 2.5 cm in width, and 0.1 cm in depth; and the sacrum measured 3.0 cm in length, 4.5 cm in width, and 0.1 cm in depth. All wounds were noted to have slough in the wound base.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an outside consultant wound report dated February 19, 2025, revealed resident with wound deterioration to the bilateral buttocks and sacrum and noted prior assessment of wounds were a stage II and now wounds present with slough and restaged to unstageable ulcers. The right buttocks measured at 2.0 cm in length, 2.0 cm in width, and 0.1 cm in depth; the left buttocks measured 2.5 cm in length, 2.5 cm in width, and 0.1 cm in depth; and the sacrum measured 3.0 cm in length, 4.5 cm in width, and 0.1 cm in depth. New treatment orders included cleansing the area with NSS, apply Santyl to the base of the wound, and secure with ABD (a gauze pad used to absorb drainage) daily and as needed.</p> <p>A review of a facility skin assessment titled Weekly Skin Evaluation dated February 21, 2025, revealed the resident had bilateral buttocks and sacrum wounds.</p> <p>A review of an outside consultant wound report dated February 26, 2025, revealed an assessment that the wounds of the right buttock, left buttock, and sacrum had merged into one ulceration with increased measurements and remain unstageable with 20% slough and 80% eschar in the wound base. The three wounds were then referred to as the sacrum wound and measured 9.0 cm in length, 10.0 cm in width, and 0.1 cm in depth. New treatment orders included cleansing the area with NSS, apply silver alginate to the base of the wound, and secure with ABD twice a day and as needed.</p> <p>A review of a facility skin assessment titled Pressure Ulcer Wound Rounds dated February 26, 2025, revealed the resident had an unstageable pressure wound. The wound assessed included the sacrum, which measured 9.0 cm in length, 10.0 cm in width, and 0.1 cm in depth. The wound was noted to have eschar in the wound base.</p> <p>A review of a sacrum/coccyx x-ray dated February 26, 2025, revealed findings that showed a question of subtle bone loss of the dorsal aspect of the sacrum/coccyx and soft tissues that appear swollen with ulceration dorsally, and cannot exclude osteomyelitis (bone infection).</p> <p>Resident CR 1 was sent out to the emergency room on February 28, 2025, for evaluation due to worsening of the sacral wound.</p> <p>An interview with the Director of Nursing (DON) on March 26, 2025, revealed the facility could not provide evidence of weight loss or treatment refusals by the resident. Additionally, the facility lacked documented evidence of consistent implementation of turning and repositioning every two hours as ordered from January 17 to February 15, 2025. Furthermore, records indicated the Juven nutritional supplement was not administered consistently on February 25, 26 and 27, 2025.</p> <p>A review of Resident CR 1's task summary reports from January 17 through February 15, 2025, failed to demonstrate that staff consistently performed scheduled turning and repositioning to prevent pressure ulcer development. Furthermore, licensed nursing staff did not develop and implement timely interventions addressing the resident's decreased mobility to prevent pressure injuries during this period.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0895</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a Compliance and Ethics Program.</p> <p>Based on policy review, review of facility documentation, and staff interviews, it was determined that the facility failed to effectively implement and enforce its compliance and ethics program in a manner that uses internal controls to more effectively monitor adherence to applicable statutes, regulations, and program requirements, in order to prevent and detect criminal, civil, and administrative violations under the Act, and promote quality of care for two employees identified (Employee 1 and Employee 2) out of two employees employed by the activity department and business office.</p> <p>Findings include:</p> <p>Review of facility's current Code of Ethics manual revealed all employees are required to undergo compliance training on the Code of Ethics as a condition of employment. The principles discussed are mandatory standards and employees must follow the code to remain employed. If an employee knows or suspects a situation is unethical, illegal, or unprofessional, the employee has an obligation to report that suspicion or concern. If an employee knows of a violation and does not report it, they could face disciplinary action for not reporting.</p> <p>Continued review of the Code of Ethics manual revealed that the Anti-Kickback statute makes it a crime to knowingly offer or receive payment or solicit anything of value to obtain or reward a referral of business under federal health care programs. In order to follow both the letter and spirit of the Anti-Kickback statute, and to avoid even the appearance of a violation, both the company and all employees will not accept or offer to provide any items of value in exchange for the referral of a patient, or a resident, or a business opportunity; nor will the company or any employee accept any item of value in return for buying services or supplies. The prohibition on offering or accepting items of value extends to anything that may influence or even appear to influence a decision regarding a healthcare service. A kickback or item of value can include cash, as well as goods, services, or gifts of more than a nominal value.</p> <p>Review of the facility's Employee Corrective Action Form dated February 13, 2025, revealed that Employee 1 (Activities Director) was terminated from employment due to a violation of Level 2 #9 Solicitation or acceptance of any gratuities or gifts.</p> <p>Review of the facility investigation dated February 4, 2025, revealed that the Nursing Home Administrator was initially informed of a situation on February 4, 2025, at approximately 1:30 PM and started an investigation.</p> <p>Review of a statement from Employee 2 (Business Office Manager) on February 4, 2025, no time indicated, revealed that Employee 2 called Employee 1 regarding unconfirmed information regarding Employee 1 receiving \$100.00 cash from an insurance vendor for assisting him in getting members signed up for his company's insurance plan. Employee 2 told Employee 1 what she had heard. Employee 1 stated I'm going to lie but not lie to you. Employee 1 said she was giving the money back to the vendor.</p> <p>(continued on next page)</p>		

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<p>F 0895</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of Employee 2's statement revealed that she witnessed conversations about receiving compensation for the vendor's insurance enrollments in the past. In September 2024, at a party, the insurance vendor spoke of compensating staff for helping him get residents on the plan. There were a few facility employees sitting at the table when he brought it up. At that time, no one entertained his conversation. Also in September 2024, there was a situation with a family member who was upset her mother was enrolled in the insurance plan. Employee 2 contacted the vendor and asked him to reach out to the resident and daughter to get on the same page about the plan. The vendor was concerned about losing the resident as a member and asked Employee 2 to talk to the resident and family. He offered to pay Employee 2 to do so. Employee 2 told the vendor to contact the family and clear it up.</p> <p>Review of a statement from Employee 1 (Activities Director) on February 5, 2025, no time indicated, revealed she accepted money from an insurance vendor for introducing the vendor to residents and/or their responsible parties. She stated that around the end of the Summer 2024, the insurance vendor began encouraging her to accept payment from him in compensation for the residents she introduced him to that were signed onto his insurance plan. Employee 1 stated she declined all offers at that time. She continued to state that the verbal encouragements from the vendor continued into the Fall 2024. By the end of November 2024, Employee 1 stated that she made a comment to the vendor that her rent increased, and the vendor reiterated his offer that he would pay her \$25.00 per person. She responded that she would do it for \$20.00 per person and that she was going to continue the way she was making the introductions before she was accepting payment. By the end of November 2024, four (4) residents had been added to the insurance plan which the vendor paid Employee 1 \$80.00.</p> <p>Employee 1 stated that she was not paid again until the week of January 5-10, 2025, which she was paid \$100.00. She acknowledged her actions were motivated by financial need and indicated the vendor had persistently encouraged the arrangement over several months.</p> <p>Employee 1 stated that on February 4, 2025, the vendor arrived at the facility and came into her office with cupcakes and \$100.00. She stated that she did not accept them because she was informed that it was illegal.</p> <p>Interview with the Nursing Home Administrator (NHA) on March 26, 2025, at approximately 4:00 PM, confirmed that Employee 1 had been terminated after an investigation was conducted which determined Employee 1 accepted money from an insurance vendor. The NHA revealed she had no knowledge that the insurance vendor had approached Employee 1 and provided monetary payments to Employee 1 for introductions/referrals. The NHA confirmed that accepting money from an outside vendor for referrals was against the facility's Code of Ethics.</p> <p>Continued interview with the NHA revealed that she was unaware that the insurance vendor spoke to Employee 2 and other facility employees at a party in September 2024, regarding compensation for obtaining referrals.</p> <p>(continued on next page)</p>		

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<p>F 0895</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Course Completion History for employee training revealed Employee 2 completed annual training on the Code of Ethics and Corporate Compliance. There was no evidence that Employee 2, or other facility employees who attended the party and witnessed the vendor openly discuss compensating staff for facilitating enrollments, reported the unethical, illegal or unprofessional behavior of the insurance vendor. Further, there was no evidence that Employee 2 reported to the NHA or compliance hotline, of the insurance vendor's unethical, illegal, or unprofessional offer to pay Employee 2 to call a family member, despite undergoing training on the mandatory obligation of employees to report an unethical, illegal or an unprofessional situation.</p> <p>Despite completing required annual Code of Ethics and Corporate Compliance training, neither Employee 1 nor Employee 2 reported these unethical solicitations to facility leadership or the compliance hotline, in direct violation of facility policy and their mandatory reporting responsibilities.</p> <p>The facility failed to effectively implement and enforce the facility's compliance and ethics program, to be effective in preventing and detecting criminal, civil, and administrative violations.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p>		