STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395265	A. Building B. Wing	09/12/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, resident council meeting minutes, and resident, resident representative, and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two residents out of the 22 residents sampled (Residents 5 and 17) and experiences reported by seven out of the 11 residents during a resident group interview (Residents 26, 30, 34, 37, 49, 50, and 69). Findings include: A review of Resident Council meeting minutes dated June 2025 through August 2025 revealed residents raised concerns regarding facility staff failing to respond timely to residents' requests for assistance. A review of the Resident Council meeting minutes dated June 25, 2025, revealed that six residents in attendance were continuing to experience long wait times for care. The issue was marked as unresolved, and a grievance was filed on the residents' behalf. A review of Resident Council meeting minutes dated July 16, 2025, revealed that five residents in attendance continued to express concerns regarding facility staff failing to respond timely to residents' requests for assistance. Documentation in the meeting minutes indicated that a grievance was filed on behalf of the residents in attendance that expressed these concerns. A review of grievances provided by the facility revealed no record of a grievance related to the resident's concerns for wait times for care or related concerns. A review of Resident Council meeting minutes dated August 20, 2025, revealed that six residents in attendance continued to express concerns regarding facility staff failing to respond timely to residents' requests for assistance. Documentation in the meeting minutes indicated that a grievance was filed on behalf of the residents in attendance that expressed these concerns. A review of grievances provided by the facility revealed no record of a grievance related to the resident's concerns for wait times for care or related concerns. During a resident group interview on September 10, 2025, at 10:00 AM, seven out of 11 residents in attendance expressed they continually experience long wait times for care despite continually bringing up this issue with staff and at resident council meetings (Residents 26, 30, 34, 37, 49, 50, and 69). During the meeting, Resident 26 indicated that she sometimes waits one hour to one and a half hours before staff responds to her call bell for assistance. She explained that recently she waited 3 hours for staff to assist her to bed. During the meeting, Resident 50 indicated that she waits the longest for staff assistance on the second shift. She explained that she often waits an hour for care and believes the issue is because there does not seem to be enough staff. During the meeting, Resident 69 indicated he waits about an hour for care. He explained that he has brought this issue up at Resident Council meetings in the past, but nothing has changed with the wait times. During the meeting, Resident 37 indicated he waits about an hour for care after ringing his call bell for assistance. He expressed frustration with the long wait times. During the meeting, Resident 49 indicated that the quickest response she experiences is about 20 minutes. She explained that staff will not provide any care during a meal, so if she needs assistance at that time, she is forced to wait longer. She expressed frustration that no one seems to care when the residents bring this issue up with staff. During the meeting, Resident 34 indicated he waits 30 minutes for staff to respond to his call bell rings for assistance. He also indicated that during meal times the wait is longer than 30 minutes. During the meeting, Resident 30 indicated she consistently waits 30 minutes or longer for staff to respond to her call bell rings for assistance. She explained that this issue has been ongoing for months. A clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and chronic kidney disease (gradual loss of kidney function). A review of an admission (following an acute hospitalization) Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 17, 2025, revealed that Resident 5 was cognitively intact with a BIMS score of 15 (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). During an interview on September 9, 2025, at 11:00 AM, Resident 5 explained that she experiences 20- to 30-minute wait times for care. She expressed frustration that it takes so long for staff to respond to her call bell when she asks for assistance. Resident 5 indicated that she has brought this issue up with staff, but nothing changes. She explained that she believes that there are not enough staff available to help residents. A clinical record review revealed that

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on a review of facility policy, the minutes from facility Resident Council meetings, and grievances filed with the facility, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to resolve continued resident complaints and grievances expressed during Resident Council meetings, including those voiced by seven of 11 residents attending a resident group meeting (Residents 26, 30, 34, 37, 49, 50, and 69), and failed to keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution.Findings include: A review of the facility's policy titled Complaint/Grievance, last reviewed on May 28, 2025, indicated the facility will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The facility will make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution. The resident should have reasonable expectations of care and services, and the center should address those expectations in a timely, reasonable, and consistent manner. The Grievance Officer or designee shall act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. A review of Resident Council meeting minutes dated June 2025 through August 2025 revealed residents raised concerns regarding facility staff failing to respond timely to residents' requests for assistance and concerns that meal trays were being delivered to resident areas but not distributed to residents in a timely manner. A review of the Resident Council meeting minutes dated June 25, 2025, revealed that six residents in attendance were continuing to experience long wait times for care. The issue was marked as unresolved for six residents in attendance, and a grievance was filed on the residents' behalf. The Resident Council meeting minutes also revealed residents raising concerns that dinner has arrived late on multiple occasions. The issue continued to be a concern from a previous meeting and was indicated as unresolved for six residents in attendance. The minutes indicated a grievance was filed. A review of Resident Council meeting minutes dated July 16, 2025, revealed that five residents in attendance continued to express concerns regarding facility staff failing to respond timely to residents' requests for assistance. Also, the minutes indicated that three residents in attendance addressed concerns that dinner is late. Documentation in the meeting minutes indicated that a grievance was filed on behalf of the residents in attendance that expressed these concerns. A review of grievances provided by the facility revealed no record that a grievance was filed related to the resident's concerns for wait times for care or late meals following the July 2025 resident council meeting. A review of Resident Council meeting minutes dated August 20, 2025, revealed that six residents in attendance continued to express concerns regarding facility staff failing to respond timely to residents' requests for assistance. Also, six residents indicated that meal trays are sitting in carts at dinner (arriving timely but not being distributed to residents) and food is becoming cold. Documentation in the meeting minutes indicated that a grievance was filed on behalf of the residents in attendance that expressed these concerns. A review of grievances provided by the facility revealed no record a grievance was filed related to the resident's concerns for wait times for care or related concerns. During a resident group interview on September 10, 2025, at 10:00 AM, seven out of 11 residents in attendance expressed they continually experience long wait times for care despite continually bringing up this issues with staff and at resident council meetings (Residents 26, 30, 34, 37, 49, 50, and 69). The residents also explained that dinner is consistently served late. Resident 50 indicated the meals arrive on time, but the trays often sit for 45 minutes to an hour before they are distributed to residents by nursing staff. Residents 26, 30, 34, 37, 49, and 69 confirmed this is an ongoing problem, and they have brought it up at resident council meetings, but the issue has not been resolved. During an interview on September 12, 2025, at 9:00 AM, the Nursing Home Administrator (NHA) indicated that there were no grievances filed on behalf of residents who raised concerns regarding the long wait times for care or late meal distribution following the July 2025 and August 2025 resident council meetings. The NHA was unable to explain why residents expressed ongoing concerns regarding the long wait times for care or late distribution of meals. The NHA was unable to provide documented evidence regarding actions the facility has taken to implement effective change and resolution to resident concerns regarding staff responding timely to residents' requests for assistance and care and late distribution of meals. Refer F550 28 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211. 12(d)(3)(4) Nursing services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS) accurately reflected the status of three residents out of 22 sampled (Residents 1, 4, and 96).Findings include: The Long-Term Care Facility RAI User's Manual (a standardized tool used in long-term care facilities to evaluate residents' strengths and needs),which provides instructions and guidelines for completing the Minimum data Set (MDS-a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 2024, requires the assessment to accurately reflect the resident's status; a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals; and the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include respiratory failure with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues) with dependence on a tracheostomy (a surgical procedure that creates an opening in the neck to access the windpipe through which a tube is inserted to help with breathing or to clear the airway) and continuous oxygen. A review of Resident 1's clinical record revealed a physician's order, dated May 19, 2025, for trach suctioning as needed. A physician's order, dated May 20, 2025, to provide trach care daily and for oxygen at 6 L (liters per minute) with 28% humidification (adds moisture to oxygen) continuously. A review of Resident 1's quarterly MDS assessment dated [DATE], revealed in Section O, Special Treatments, for 0110C2 continuous oxygen therapy, that the resident was not receiving continuous oxygen therapy; for 0110D3 suctioning as needed, it indicated the resident was not receiving as-needed suctioning; and for 0110E1 tracheostomy care, it indicated that the resident was not receiving tracheostomy care. A review of Resident 1's Treatment Administration Record during September 2025 revealed the resident was receiving tracheostomy care, continuous oxygen therapy, and suction as needed, as ordered by the physician. An interview with the Nursing Home Administrator (NHA) on September 12, 2025, at 8:30 AM confirmed the resident was receiving tracheostomy care, along with continuous oxygen therapy and as-needed suctioning during the period reviewed for the quarterly MDS assessment dated [DATE]. A review of Resident 96's clinical record revealed the resident was admitted to the facility on [DATE], and had diagnoses, which include schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). A review of Resident 96's annual MDS assessment dated [DATE], indicated that Section A1500 was coded as 0, indicating the resident was not considered by the State to require a Level II PASARR (process, to have serious mental illness, and/or to have intellectual disability or mental retardation or a related condition. (Preadmission Screening and Resident Review [PASARR] is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. However, a review of Resident 96's clinical record revealed a Level I PASARR was completed on February 2, 2018, which indicated the resident did meet the criteria for a Level II PASARR. A determination letter dated February 12, 2018, from the Pennsylvania Department of Health Office of Mental Health and Substance Abuse confirmed Resident 96's need for specialized services due to a mental condition. An interview with the NHA on September 12, 2025, at 8:30 AM confirmed that the Annual MDS assessment dated [DATE], for Resident 96 was inaccurate with respect to the completion of Section A 1500 related to the PASARR. A clinical record review revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included quadriplegia (a condition that results in the paralysis of all four limbs). A review of Resident 4's admission MDS assessment dated [DATE], Section H Bladder and Bowel, H0100 Appliances - Indwelling Catheter (including suprapubic catheter and nephrostomy) with instructions to mark all that apply, revealed the resident was assessed to have an indwelling catheter. During an observation on September 9, 2025, at 10:45 AM, an indwelling urinary catheter was not present or observed. During an interview on September 12, 2025, at 8:30 AM, the NHA confirmed that Resident 4's MDS admission assessment was not accurate with respect to Section H Bladder and Bowel- H0100 Appliances. 28 Pa. Code 211.5(f)(iii)(ix) Medical records. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policy, and staff interview, it was determined the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised as needed to accurately reflect the current needs and services required by one of 22 residents sampled (Resident 96). Findings include: A review of the facility policy entitled Comprehensive Care Plans last reviewed on May 28, 2025, revealed the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. A clinical record review revealed Resident 96 was admitted to the facility on [DATE], with diagnoses which included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), depression, and anxiety. A nurses note date June 2, 2025, indicated the resident was transferred to the hospital and admitted with a Hospital 302 (involuntary psychiatric commitment under Section 302 of Pennsylvania's Mental Health Procedures Act which allows a person to be admitted to a hospital for emergency psychiatric evaluation and treatment if they are a danger to themselves or others due to a mental illness) for verbal and physical aggression toward staff and verbal aggression toward another resident. Resident 96 was readmitted to the facility from a behavioral hospital on June 17, 2025, with diagnosis which included schizophrenia. Review of the behavioral hospital's Patient Safety Plan for the resident noted that red flags and warning signs (things that indicate a crisis may be developing, they can be big signs or little ones. Sometimes they are thoughts, images, moods, certain situations or behaviors that indicate things are not going well) include increase in paranoia (mental health condition characterized by an irrational and persistent fear or distrust of others), presence of auditory hallucinations (false perceptions of sound, such as hearing voices or noises that are not present) and visual hallucinations (perception of a vivid image, scene, or object that is not actually there, occurring without an external stimulus to cause it), and increase in agitation. Internal Coping Strategies included deep breathing and activity. The plan also noted that the resident identified his family as the most important thing that is worth living for. A review of Resident 96's comprehensive care plan, initially dated December 11, 2018, indicated a focus concern that the resident has a behavior problem related to hallucinations/delusions (no description of recent episodes or type of hallucinations/delusions), angry outbursts, mood swings, hears voices, slamming of his door, refusing care, picks at right cheek and applies toothpaste to the area with a diagnosis of schizoaffective disorder (a type of schizophrenia which is diagnosed when depression is present for the majority of time when they also experience symptoms like hallucinations, delusions, and disorganized thinking). The care plan failed to identify the resident had a diagnosis of schizophrenia. The goal last revised September 4, 2025, was for the resident to have fewer episodes of mood swings, outbursts, and hallucinations daily. A review of interventions last revised December 16, 2024, failed to reflect the resident's red fags and warnings signs, internal coping strategies, and the importance of the resident's family as identified in the behavioral hospital's Patient Safety Plan. The care plan failed to indicate that the resident's behaviors escalated to the extent that a Hospital 302 and Inpatient Behavioral Hospital stay was needed to address and evaluate the resident's mental health needs. An interview with the director of nursing on September 11, 2025, at 10:00 AM failed to provide documented evidence that the facility reviewed and revised Resident 96's care plan to accurately reflect his current mental health status, risks, and required interventions. 28 Pa. Code 211.10 (a)(b)(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to thoroughly assess, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice, for one resident out of 22 sampled (Resident 8) and failed to provide person-centered care to meet the clinical needs by failing to monitor intravenous therapy (a way of giving medication or fluids through a needle or tube inserted into a vein) in accordance with professional standards of practice for one of 22 residents sampled (Resident 1). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient's designated support person. Clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses to include first-degree atrioventricular block (AV block-a heart rhythm disorder), hypertension (high blood pressure), and Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions).A review of Resident 8's hospital records dated September 16, 2024, indicated the resident underwent a cardiac pacemaker implantation (device implanted in the body to deliver electrical impulses to the heart to help the heart beat at a normal rate and rhythm) on August 18, 2021. A review of Resident 8's admission assessment dated [DATE], failed to document the presence of a pacemaker upon the resident's admission to the facility. Review of Resident 8's physician orders failed to identify the presence of, or care for, the resident's pacemaker. Review of Resident 8's plan of care, in effect at the time of the survey ending September 12, 2025, identified that Resident 8 had altered cardiovascular status due to hypertension and first-degree AV block. The facility failed to identify the presence of, or the care for, the resident's implantable pacemaker on the resident's current plan of care. Interview with the Director of Nursing on September 12, 2025, at 9:30 AM confirmed the facility failed to identify or include the pacemaker in the resident's admission assessment and comprehensive care plan. A review of the facility policy titled Short Peripheral Intravenous Catheter (PIVC) Insertion, last reviewed by the facility on May 28, 2025, revealed it is the policy of the facility that assessment of the PIVC site is performed during dressing changes, at least every two hours during continuous therapy, before and after administration of interim intravenous medication, at least once every shift when not in use, and routinely for signs and symptoms of IV-related complications. Further review of the policy revealed that documentation in the medical record includes date and time performed, verbal consent, catheter type, gauge, and length, site location, site assessment, and dressing type. A review of the facility policy titled Peripheral Intravenous Catheter Flushing, last reviewed by the facility on May 28, 2025, revealed it is the policy of the facility to obtain specific flush orders, and that flushing is performed to ensure and maintain catheter patency.A review of the facility policy titled Short PIVC Dressing Change, last reviewed by the facility on May 28, 2025, revealed it is the policy of the facility that transparent dressings are changed with each site rotation every seven days or sooner if the integrity of the dressing is compromised.A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include respiratory failure with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues) with dependence on a tracheostomy (a surgical procedure that creates an opening in the neck to access the windpipe through which a tube is inserted to help with breathing or to clear the airway) and continuous oxygen. A review of Resident 1's clinical record revealed a physician's order, dated September 5, 2025, for Zosyn (an antibiotic) 3.375 grams IV three times a day for five days due to sputum culture infection. A review of Resident 1's clinical record revealed a physician's order, dated September 6, 2025, for a peripheral IV to be placed due to IV antibiotics. Observation of Resident 1 on September 9, 2025, at 11:40 AM, revealed the peripheral IV catheter was present in the resident's left hand with a date on the dressing of September 7, 2025. A review of the clinical record for Resident 1 revealed no documented evidence of a physician order for care and monitoring of the peripheral IV site. Following surveyor inquiry, a review of Resident 1's physician's orders

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, select policy review, and staff interviews, it was determined the facility failed to provide care and services designed to prevent potential complications associated with enteral tube feedings for one resident receiving enteral nutrition out of 22 residents sampled (Resident 8).Findings include: Review of the facility policy titled Enteral Feeding -Enteral Nutrition Pump last reviewed by the facility April 28, 2025, indicated that nurses are responsible for administering enteral feedings (a method of providing nutrition directly into the gastrointestinal tract) when volume control is indicated and as ordered by the physician. The policy further states that closed system enteral feeding containers and tubing can hang safely for up to 48 hours. Clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses to include dysphagia (difficulty swallowing), and Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions).Resident 8 required a PEG tube (Percutaneous endoscopic gastrostomy is an endoscopic medical procedure in which a tube is passed into the patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate).The resident had a physician order, dated June 25, 2025, for continuous enteral feeding with Jevity 1.2 at 65 ml/hour (a liquid high calorie enteral feeding formula). Observation of the resident on September 9, 2025, at 12:08 PM revealed the resident was lying in bed. The tube feeding and pump were running and delivering enteral feedings to the resident. The tube feeding container lacked a label indicating the date and time it was opened and hung, which is necessary to ensure safe administration within the recommended 48-hour timeframe. Further observation identified a feeding pole attached to the resident's wheelchair that was coated with a dried tan residue. The same residue was observed on multiple wheelchair surfaces, including the seat cushion, seat support, back support, armrests, and wheels.Interview with the Nursing Home Administrator on September 12, 2025, at 10:30 AM, confirmed that housekeeping is responsible for scheduled cleaning of all wheelchairs and that all staff are expected to clean wheelchairs immediately when they become soiled. The facility failed to ensure proper labeling of enteral feeding containers when opened and hung, and failed to maintain resident equipment, specifically the wheelchair and feeding pole, in a sanitary condition. These deficiencies increase the risk of infection and other complications related to enteral feeding. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services. 28 Pa. Code 211. 10 (c)(d) Resident care policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395265	A. Building B. Wing	09/12/2025

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma-informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 22 residents reviewed (Resident 98). Findings include: A review of the facility policy titled Trauma Informed Care, last reviewed by the facility on May 28, 2025, revealed it is the policy of the facility to provide care and services that, in addition to meeting professional standards, are delivered using approaches that are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization.A review of Resident 98's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event) and anxiety (a mental condition that causes a feeling of worry, nervousness, or unease).A review of an outside psychiatry consultation for Resident 98 dated August 21, 2025, revealed no mention of history for PTSD. The resident's current care plan, in effect at the time of review on September 10, 2025, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident-specific interventions to meet the resident's needs for minimizing triggers and re-traumatization. The facility failed to develop and implement an individualized person-centered plan to address Resident 98's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety. An interview with the Nursing Home Administrator and Social Services Director on September 10, 2025, at 10:00 A.M., confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for the resident's experiences and preferences to eliminate or alleviate triggers that may cause re-traumatization of the resident. 28 Pa Code 211.12 (d)(3)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395265	A. Building B. Wing	09/12/2025

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

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interviews, it was determined that the facility failed to maintain accurate and complete clinical records for one of 22 sampled residents (Resident 5). Findings include: A clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and chronic kidney disease (gradual loss of kidney function). A physician's order for Resident 5 to receive Cefazolin (an antibiotic medication) sodium injection solution reconstituted to 2.0 g with directions to use 2.0 grams intravenously every eight hours for MRSA (methicillin-resistant Staphylococcus aureus -a type of bacterial infection that can be resistant to antibiotic medications) for 15 days was initiated on August 15, 2025. A review of Resident 5's medication administration record (MAR) dated August 2025 revealed there was missing documentation for seven scheduled administrations of Cefazolin Sodium Injection Solution Reconstituted 2.0 g. There was no documentation for the administration of cefazolin sodium injection solution reconstituted to 2.0 g on the following dates: August 18, 2025, at 2:00 PMAugust 22, 2025, at 2:00 PMAugust 25, 2025, at 2:00 PMAugust 27, 2025, at 2:00 PMAugust 28, 2025, at 6:00 AMAugust 28, 2025, at 2:00 PM During an interview on September 12, 2025, at 9:00 AM, the Nursing Home Administrator (NHA) indicated that nursing staff omitted the information from the clinical record. The NHA provided an attestation from Employee 1, Registered Nurse (RN), indicating that she administered Resident 5's cefazolin antibiotic medication but forgot to document it in the Electronic Health Record. The NHA confirmed that it is the facility's responsibility to ensure accurate and complete medical records. 28 Pa. Code 211.5(f)(ii) Medical records. 28 Pa. Code 211.12(d)(1)(5) Nursing services.