STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395316	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Luke's Rehabilitation and Nursing Center	360 West Ruddle Street Coaldale, PA 18218

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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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for one of 12 residents reviewed (Resident 25) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 25 was admitted to the facility on [DATE], with diagnoses to include dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated August 30, 2024, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 9 indicating moderate cognitive impairment. A review of the resident's comprehensive care plan, reviewed during the survey ending November 7, 2024, revealed that a discharge plan was developed upon admission February 22, 2024 with no revisions noted, indicating the residents desire to be discharged to the community. A review of the clinical record revealed a social service progress note dated August 30, 2024, indicating the resident was a long term placement in the facility. There were no further notes or revisions to Resident 25's care plan to reflect this change in his discharge planning. During an interview with the Director of Nursing on November 6, 2024, at 12:00 PM confirmed there was no documented evidence that an individualized discharge care plan to reflect discharge planning for Resident 25 was developed and updated to reflect Resident 25's goal to return to the community. 28 Pa. Code 201.29 (a) Resident rights.

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: 395316	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
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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** 48276 Based on a review of clinical records, observations, staff, and resident interviews, it was determined the facility failed to ensure that residents receive care consistent with professional standards of practice to prevent pressure sore development for one of 13 residents sampled (Resident 28). Findings include: 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. A clinical record review revealed Resident 28 was admitted to the facility on [DATE], with diagnoses that include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). He was admitted to the facility with necrotic diabetic ulcers and multiple pressure injuries, including a Stage IV sacrum injury (a severe wound that involves full-thickness tissue loss and exposure of underlying bone, muscle, tendon, ligament, or cartilage). A wound observation tool dated April 13, 2023, revealed Resident 28's stage IV sacrum pressure injury healed. The tool indicated the special equipment and prevention measures in place included a P 500 bed mattress (a therapy bed surface instrument designed to help prevent and treat shear, friction, and pressure injuries through microclimate adjustments, repositioning, and automatic weight redistribution). On October 12, 2023, a physician issued an order for Resident 28 to utilize a P-500 mattress for wound care, which was subsequently discontinued on February 9, 2024. A care plan revealed Resident 28 has a history and problem with diabetic ulcer areas related to immobility and history of poor intake and a stage IV sacral area that resolved on April 13, 2023. The goal indicated is for Resident 28 to have intact skin free of redness, blisters, or discoloration through the next review date. Interventions included a flat sheet applied to the resident's P-500 mattress as ordered, initiated on October 14, 2023, and discontinued on February 9, 2024. An alternating air mattress for pressure reduction was implemented for Resident 28 on February 8, 2024. Other interventions in place to help Resident 28's skin remain intact included turning and repositioning the resident every two hours, cleansing his buttocks and sacrum with soap and water, patting dry, and applying border foam. A clinical record review of tasks and interventions from February 8, 2024, through February 24, 2024, revealed the tasks and interventions were documented as completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Braden Scale for Predicting Pressure Sore Risk dated February 10, 2024, revealed Resident 28 is at risk for developing pressure injuries. A wound observation tool dated February 24, 2024, revealed Resident 28 developed a new open pressure injury on his sacrum measuring 4.0 cm x 2.5 cm x 0.5 cm with macerated(skin that looks light wrinkly and wet can be a result of contact with moisture) edges. A wound care note dated February 29, 2024, indicated Resident 28 has a Stage IV pressure injury to his sacrum measuring 3.2 cm x 3.2 cm x 1.0 cm with undermining 9-12 cm of 1.0 cm (when the wound's edges erode, creating a pocket beneath the skin). The wound had moderate tan drainage, macerated and thick edges, and a 100% granular wound bed. The note also indicated recommendations for Resident 28 to utilize a P-500 low-air-loss mattress. A review of Resident 28's physician's order revealed the P 500 low air loss mattress was initiated on February 24, 2024, following Resident 28 developing a stage IV pressure injury to his sacrum. A wound observation tool dated November 7, 2024, revealed Resident 28's Stage IV sacral wound measured 2.5 cm x 1.5 cm x 0.7 cm with undermining of 0.7 cm with rolled macerated edges and a wound bed of 50% fibrotic tissue and 50% granular tissue. During an interview on November 7, 2024, at 9:30 AM, Resident 28 declined to allow surveyors to observe his wound. During an interview on November 7, 2024, at 10:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure residents do not develop pressure injuries unless clinically unavoidable. The NHA confirmed the facility discontinued the use of the P-500 low-loss air mattress on February 9, 2024, which contributed to the development of Resident 28's Stage IV sacrum pressure injury on February 24, 2024. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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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** 48276 Based on a review of clinical records, information submitted by the facility, select facility reports, and resident and staff interview it was determined the facility failed to implement effective safety measures to prevent a fall for one out of the 13 sampled residents (Resident 9). Findings include: A clinical record review revealed Resident 9 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (a condition that occurs when the heart can't pump enough blood to the body) and chronic kidney disease (gradual loss of kidney function). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 17, 2024, revealed that Resident 9 is 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). A facility investigation report dated April 22, 2024, revealed Resident 9 fell from a transport van while out of the facility for an appointment. The report indicated that while the transport van was parked outside the facility, Employee 1, Vehicle Operator, pushed the resident out of the vehicle without realizing the lift chair was on the ground, resulting in the resident falling out of the vehicle to the ground. Review of the resident's clinical record revealed a progress note dated April 22, 2024, at 2:53 PM, indicated Resident 9 had an incident at the hospital entrance upon returning from a podiatry appointment. She was sent directly to the emergency department for assessment. The physician and resident representatives were notified. A progress note dated April 22, 2024, at 7:45 PM, indicated Resident 9 returned from the emergency department in stable condition. She is alert and oriented; neurological checks and assessments have been completed. The note indicated Resident 9 is in her room and denying discomfort. A progress note dated April 23, 2024, at 1:17 AM indicated neurological checks were completed for Resident 9 with no deficits noted. She is alert, oriented, and able to make needs known. Resident 9 reports mild generalized aches. She is able to move in bed without difficulty. No bruising or swelling to the head. A new bruise was noted on her left upper buttock measuring 1.0 cm x 1.0 cm and her left lateral thigh that measures 0.7 cm x 0.7 cm. A practitioner progress note dated April 24, 2024, at 10:21 PM indicated Resident 9 fell from the wheelchair van and suffered some bruising. No fractures were noted, and she denies any significant pain at this point. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated April 26, 2024, at 10:44 AM revealed Resident 9 received a psychiatric evaluation following her fall with a head strike. The note indicated Resident 9 was screened and evaluated and determined as not exhibiting any symptoms of depression, anxiety, mania, or paranoia. A physician's order for Acetaminophen Oral Tablet 325 mg with instruction to give three tablets by mouth every eight hours as needed for mild pain initiated on April 13, 2024. A review of Resident 9 Medication Administration Record dated April 2024, revealed she received Acetaminophen Oral Capsule on the following dates: April 22, 2024, at 9:41 PM for a pain level 4 out of 10 April 23, 2024, at 5:37 AM for a pain level 3 out of 10 April 23, 2024, at 9:14 PM for a pain level 5 out of 10 April 24, 2024, at 9:19 PM for a pain level 4 out of 10 April 25, 2024, at 9:01 PM for a pain level 4 out of 10 April 26, 2024, at 11:47 PM for a pain level 3 out of 10 April 28, 2024, at 2:00 AM for a pain level 3 out of 10 April 30, 2024, at 12:20 AM for a pain level 3 out of 10 April 30, 2024, at 10:16 AM for a pain level 2 out of 10 During an interview on November 5, 2024, at 11:15 AM, Resident 9 indicated that she fell a few months ago (approx 6 months) from a transport vehicle when a lift operator failed to secure the lift locking mechanism. She explained that she rolled back and fell out of the vehicle and hit her head. Resident 9 indicated the experience was very unpleasant and frightening. During an interview on November 7, 2024, at 10:30 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure effective safety measures are implemented to prevent residents from falling. The NHA confirmed that Employee 1, Vehicle Operator from contracted transportation company, failed to follow the appropriate safety measures (i.e. securing the lock and lift positioning), resulting in Resident 9 falling out of the vehicle, striking her head, and sustaining pain and bruising with no major injury. The vehicle operator resigned from the transportation company. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an effective individualized person-centered plan to address a resident's dementia-related behavioral symptoms for two out of 13 residents reviewed (Resident 12 and 25). Findings include: A review of Resident 12's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and generalized anxiety disorder (a mental condition characterized by excessive or unrealistic anxiety about two or more aspects of life). A review of a behavior note dated August 23, 2024, at 8:00 PM revealed the resident was verbally aggressive and argumentative with staff. The resident was noted to be yelling, cursing, slamming items on the bedside table, and throwing things on the floor. Further it was documented the resident would become more agitated when staff tried to talk to her. The resident's current care plan for impaired cognitive function related to dementia, did not identify the resident's specific behaviors the resident exhibits and specific person centered interventions to address each of these behaviors. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage the resident's dementia-related behavioral symptoms. A review of Resident 19's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). A review of a behavior notes between August 12, 2024, and end of survey November 7, 2024 revealed the resident was having increasing behaviors. The resident was noted to be yelling, crying, agitation, accusatory to staff, refusing care and hitting out at staff. Further it was documented the resident was often difficult to redirect The resident's current care plan for impaired cognitive function related to dementia, did not identify the resident's specific behaviors the resident exhibits and specific person centered interventions to address each of these behaviors. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage the resident's dementia-related behavioral symptoms. An interview with Nursing Home Administrator on November 7, 2024, at approximately 1:00 PM, confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address dementia-related behaviors. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review clinical records and staff interviews, it was determined the facility failed to ensure that a resident was free from unnecessary psychoactive drugs by failing to ensure the presence of clinical rationale for the continued use of an as needed psychotropic medication for one of 13 residents reviewed (Resident 12). Findings include: A review of Resident 12's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and generalized anxiety disorder (a mental condition characterized by excessive or unrealistic anxiety about two or more aspects of life). A review of Resident 12's clinical record revealed a physician's order dated June 29, 2024, for Lorazepam (antianxiety medication) tablet 0.5 MG, give 0.5 MG by mouth every 8 hours as needed for Anxiety or shortness of breath for 60 days. A review of the resident's June 2024 Medication Administration Records (MAR commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a resident at a facility by a health care professional. The MAR is a part of a resident's permanent record on their medical chart. The health care professional signs off on the record at the time that the drug or device is administered) revealed the as needed Lorazepam was administered on June 29, 2024. A review of the resident's July 2024 MAR revealed the as needed Lorazepam was administered just once on July 9, 2024. A review of the resident's August 2024 MAR revealed the as needed Lorazepam was administered just once on August 30, 2024. A review of the resident's clinical record revealed the physician failed to document the clinical rationale for the extended use of an as needed antianxiety medication at the time it was ordered. An interview was conducted with the Director of Nursing on November 7, 2024, at approximately 1:00 PM confirmed there was no physician documentation of the clinical rationale for the as needed medication to be used more than 14 days. 28 Pa. Code 211.2(d)(3) Medical Director