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	06/24/2026

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

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, review of the Resident Assessment Instrument (RAI) User's Manual, and resident representative and staff interviews, it was determined the facility failed to complete a comprehensive Significant Change in Status Assessment using the Minimum Data Set (MDS) after a significant decline in physical functioning for one of six residents reviewed (Resident 50).Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated October 2025, the facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition. The RAI Manual indicates a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. Clinical record review revealed Resident 50 was admitted to the facility on [DATE], with diagnoses that included chronic diastolic heart failure (a condition in which the heart has difficulty relaxing and filling properly with blood) and chronic kidney disease Stage 3b (moderate to severe loss of kidney function in which the kidneys operate at approximately 30 to 44 percent of normal capacity). An admission Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 50 was moderately cognitively impaired with a BIMS score of 10 (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 8 through 12 indicates cognition is moderately impaired). The assessment documented the resident required set-up assistance for eating, partial to moderate assistance with transfers, ambulated up to 10 feet with partial to moderate assistance, was frequently incontinent of bladder (loss of urinary control), and occasionally incontinent of bowel (loss of bowel control). A nurses' note dated May 30, 2026, documented Resident 50 sustained a fall, was transferred to the hospital, and was admitted with a closed left hip fracture (a break in the upper thigh bone in which the bone does not penetrate the skin).A nurses' note dated June 8, 2026, documented the resident returned to the facility following surgical repair of the left hip fracture.Physician orders dated June 9, 2026, directed staff to transfer the resident using a Hoyer lift (a mechanical lifting device used to safely transfer individuals who cannot bear weight) and to position the resident in a Broda chair (a specialized medical wheelchair that provides advanced positioning, pressure redistribution, and support for individuals with significant mobility limitations) when out of bed. The quarterly MDS dated [DATE], documented Resident 50 had declined to a BIMS score of 9, now required maximal assistance with eating, maximal assistance with transfers, was no longer ambulatory, and was always incontinent of both bladder and bowel. Observation of Resident 50 on June 23, 2026, at 12:40 PM revealed the resident was seated in a reclined Broda chair in her room. During an interview at that time, the resident representative stated the resident experienced a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significant decline following the fall that resulted in the hip fracture and subsequent surgery. Review of the clinical record revealed no documentation that the facility completed a comprehensive Significant Change in Status Assessment after the resident experienced a major decline affecting multiple areas of health status, including mobility, transfers, eating ability, continence, and functional independence. During an interview on June 24, 2026, at 9:00 AM the Registered Nurse Assessment Coordinator (RNAC) confirmed the facility did not complete a comprehensive Significant Change in Status Assessment. The RNAC acknowledged the resident's decline following the hip fracture and surgical repair met the criteria for a significant change and confirmed the facility should have completed a Significant Change in Status Assessment in accordance with the RAI User's Manual. 28 Pa. Code 211.5 (f)(ii)(ix) Medical records. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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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** Based on observations, a review of clinical records, the alternating air mattress manufacturer's instructions, facility policies, and staff interviews, it was determined the facility failed to consistently implement individualized pressure injury prevention interventions in accordance with physician orders, wound care recommendations, manufacturer instructions, and each resident's assessed risk for pressure injury for two of six residents reviewed (Residents 7 and 16).Findings include:A review of the facility's policy entitled Prevention of Pressure Injuries, last reviewed February 3, 2026, directed staff to follow current standards of practice for pressure injury prevention and to individualize interventions based on each resident's risk factors for pressure, injury, clinical condition and resident wishes and goals for care. The policy further directed staff to select appropriate pressure redistribution support services based on the residents' risk factors in accordance with current recommended practice guidelines (NPIAP, National Pressure Injury Advisory Panel) and to ensure the full body support surface accommodates the weight, height, size, and body mass index of the resident. A review of the facility's policy entitled Pressure Ulcers Skin Breakdown, last reviewed on February 3, 2026, indicated the facility protocol for residents is that the provider will order pertinent wound treatments, including pressure redistribution surfaces, wound cleansing, and dressings. A review of the facility's alternating air mattress manufacturer's instruction manual revealed that the resident weight setting allows the caregiver to set the mattress to a comfortable pressure by using the weight scale as a guide. The pressure of the mattress can be adjusted by choosing the patients' corresponding weight setting using the pressure adjust knob which goes from 80 pounds (soft) to 350 pounds (firm). Pressure levels will range soft to firm based on the weight setting chosen with the pressure adjust knob. According to the National Pressure Injury Advisory Panel (NPIAP), pressure redistribution support surfaces should be selected according to the resident's clinical condition, weight, size, and pressure injury risk. Manufacturer recommendations should be followed to ensure the support surface functions as intended.A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that include peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs), chronic heart failure (heart muscle is weakened and cannot pump blood efficiently to meet the body's needs), and 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). A physician order dated April 28, 2026, noted the resident was admitted to Hospice for a diagnosis of critical limb ischemia (advanced, severe stage of peripheral artery disease (specific type of peripheral vascular disease) where heavily blocked arteries significantly reduce blood flow to the limbs) of the right lower extremity. A physician's order dated April 30, 2026, noted low air loss mattress (specialized medical support surface designed to prevent and treat pressure ulcers) for pressure reduction. Check function every shift. The resident's weight record revealed the resident weighed 202.6 pounds on June 6, 2026. An observation conducted on June 24, 2026, at 9:40 AM revealed Resident 7 was in bed. The low air loss mattress weight setting was adjusted to approximately 320 pounds rather than the resident's documented weight. During an interview on June 24, 2026, at 10:10 AM, Employee 1, Registered Nurse, stated staff checked each shift to ensure the mattress was functioning but did not verify or adjust the therapeutic weight setting. A second observation conducted on June 24, 2026, at 11:00 AM revealed the low air loss mattress remained set at approximately 320 pounds. During an interview conducted on June 24, 2026, at 11:00 AM, Employee 2, Hospice Registered Nurse, confirmed the mattress was not adjusted to the resident's weight. Employee 2 stated the durable medical equipment supplier initially set the mattress when it was delivered but could not explain why the mattress remained set at approximately 320 pounds rather than the resident's documented weight to provide optimal pressure redistribution. A clinical record review revealed Resident 16 was admitted to the facility on [DATE], with diagnoses (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that include peripheral vascular disease and generalized muscle weakness (decrease in muscle strength across multiple body parts). A review of Resident 16's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 10, 2026, revealed that Resident 16 was cognitively intact with a BIMS score of 13 (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 through 15 indicates cognition is intact). A care plan initiated on November 21, 2025, indicated Resident 16 had a potential and actual skin impairment for skin injury related to fragile skin and indicated the resident had various skin impairments since admission, which included pressure wounds (wound caused by prolonged pressure or friction), traumatic wounds (wound caused by injury) and arterial wounds (wound that is caused by poor circulation). Interventions implemented to assist Resident 16 with her goal to maintain clean and intact skin included using pressure-relieving devices as indicated for the wheelchair and weekly skin evaluations and weekly wound rounds. A Braden Scale assessment dated [DATE], identified the resident as being at moderate risk for pressure injury development. An outside wound care nurse progress note dated June 16, 2026, revealed Resident 16 had arterial and traumatic wounds noted on the left ankle, left great toe, left top of the foot, left lateral foot, left knee, left second toe, left heel, left fourth toe, right elbow hematoma (collection of blood due to an injury), left shin, and left third toe. The wound care nurse recommended implementation of an alternating air mattress for pressure reduction with function checks every shift in addition to use of a cupped mattress (raised edges) for fall prevention. An observation on June 23, 2026, at 1:30 PM revealed Resident 16 was in their cupped mattress bed with no alternating air mattress attached. A second observation on June 24, 2026, at 10:00 AM, revealed Resident 16 in their wheelchair in their room, and there was no alternating air mattress attached to the bed. A review of physician orders for Resident 16 during the time of the survey did not identify an order for an alternating air mattress. During an interview on June 24, 2026, at 11:00 AM, the Director of Nursing (DON) confirmed the resident did not have an alternating air mattress on their bed due to the resident having a cupped mattress to help prevent falls. During an interview on June 24, 2026, at 11:30 AM, the above information was reviewed with the DON and Nursing Home Administrator (NHA). The facility failed to consistently implement preventive interventions to help prevent the development of pressure injuries, including the application of an alternating air mattress, and ensure the physician ordered low air loss mattress was operated in a manner to reduce the likelihood of pressure injury development to the fullest extent possible. 28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.