STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395591	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luther Crest Nursing Facility	800 Hausman Road Allentown, PA 18104

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 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 17709 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to notify the residents and the residents' representatives of transfers from the facility and reasons for the moves in writing for two of three sampled residents who were transferred to the hospital. (Residents 2, 39) Findings include: Review of the facility policy entitled, Bed-Holds and Returns, last reviewed January 25, 2024, revealed that prior to transfers the residents and resident representatives were to be informed in writing of the details of the transfer per the Notice of Transfer. Clinical record review revealed that Resident 2 was transferred and admitted to the hospital on March 29, 2024, after a change in condition. Clinical record review revealed that Resident 39 was transferred and admitted to the hospital on February 23, and April 17, 2024, after a change in condition. In an interview on July 11, 2024, at 9:30 a.m., the Administrator stated that there was no documented evidence that the residents or the residents' representatives were given the information in writing of the details of the transfer as per the facility policy.

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 0625 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 17709 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide a written notice of the facility's bed-hold policy (an agreement for the facility to hold a bed for an agreed rate during a hospitalization) to the resident, family member, or legal representative at the time of the transfer out of the facility for two of three sampled residents who were transferred to the hospital. (Residents 2, 39) Findings include: Review of the facility's policy entitled, Bed-Holds and Returns, last reviewed January 25, 2024, revealed that prior to transfers, residents or resident representatives were to be informed in writing of the bed-hold and return policy. Clinical record review revealed that Resident 2 was transferred and admitted to the hospital on March 29, 2024, after a change in condition. Clinical record review revealed that Resident 39 was transferred and admitted to the hospital on February 23, 2024, and April 17, 2024. In an interview on July 11, 2024, at 9:30 a.m., the Administrator stated that there was no documented evidence that the residents or the residents' representatives were given information regarding bed-holds after their transfers out to the hospital as per facility policy.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17709 Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide services to improve and/or maintain activities of daily living that included ambulation for three of 14 sampled residents. (Residents 2, 7, 40) Findings include: Clinical record review revealed that Resident 2 had diagnoses that included a history of fractured ribs, vascular dementia, and muscle weakness. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was alert and oriented and required supervision/touching assistance with ambulation. Review of the restorative program plan of care that was recommended by physical therapy on January 5, 2024, indicated that the recommendation was for a restorative ambulation program to be implemented by staff. The goal was for the resident to maintain the current level of mobility of walking 200 feet, two times a day with a roller walker and assistance of one person. A review of the current care plan revealed that the resident was on a restorative nursing program for ambulation. The intervention was for the resident to ambulate 200 plus feet with a walker and assist of one two times a day. Review of nursing documentation for the last 30 days revealed that there was a total of six times that the resident was only offered assistance with walking one time a day. In addition, there was a total of five days that there was no documented evidence that the staff had assisted the resident at all with the restorative ambulation program. Clinical record review revealed that Resident 7 had diagnoses that included polyosteoarthritis, age related physical disability and difficulty walking. The MDS assessment dated [DATE], indicated that the resident was alert and used a walker for ambulation. On May 30, 2024, a physician documented that the resident was alert and communicative. Review of a physical therapy discharge summary dated March 11, 2024, indicated that the resident had met the goal of walking 50 feet with a walker, with supervision and stand by assistance for safety. The summary further indicated that the resident had reached maximum potential and the recommendation was for staff to provide a restorative program for ambulation. Review of the current restorative plan of care that had been initiated by physical therapy revealed that the resident was to ambulate 20 to 50 feet one to two times a day with a roller walker and assist of one with a gait belt. Review of nursing documentation for the last 30 days revealed that there was a total of 14 times that the resident was only offered assistance with walking one time a day. In addition, there was a total of three days that there was no documented evidence that the staff had not assisted the resident at all with the restorative ambulation program. In an interview on July 10, 2024, at 10:16 a.m., the resident stated that she does like to walk, but that she was not offered assistance to walk daily on a consistent basis. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clinical record review revealed that Resident 40 had diagnoses that included Alzheimer's disease, dementia, and high blood pressure. The MDS assessment dated [DATE], indicated that the resident had confusion, but could usually communicate with and understand others. Review of a physical therapy discharge summary dated June 10, 2024, indicated that the resident had met the goal of walking 75 feet with a walker, with a minimum of one assistance for safety. The summary further indicated that the resident had reached maximum potential and the recommendation was for staff to provide a restorative program for ambulation. Review of the current restorative plan of care that had been initiated by physical therapy revealed that the resident was to ambulate 50 to 100 feet daily with a roller walker and assist of one with a gait belt and a wheelchair to follow. Review of nursing documentation for the last 30 days revealed that there was a total of 15 days that there was no documented evidence that staff had assisted the resident at all with the restorative ambulation program. In an interview on July 11, 2024, at 9:30 a.m., the Director of Nursing stated that there was no documented evidence that the restorative ambulation programs had been consistently offered to the aforementioned residents as recommended by physical therapy. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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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** 48578 Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide treatment in accordance with physician's orders for one of three sampled residents with pressure ulcers. (Resident 19) Findings include: Clinical record review revealed that Resident 19 had diagnoses that included heart failure and muscle weakness. The Minimum Data Set assessment dated [DATE], indicated that the resident required assistance from staff for personal hygiene. Review of the care plan revealed that there was a risk for skin impairment related to the resident's fragile skin, decreased mobility, and incontinence. Review of a nursing note dated May 31, 2024, indicated that the resident had a new pressure related wound on the buttocks. On July 5, 2024, a physician ordered for staff to cleanse and provide a treatment to the wound twice a day on the day and evening shift and as needed for dislodgement of the dressing. Observation on July 10, 2024, at 9:45 a.m., of a wound treatment for Resident 15 with the licensed practical nurse (LPN1) revealed that the dressing to be removed had a date of July 9, 2024, and the initials matched those of the LPN1. In an interview at the time of the observation, LPN1 confirmed that the old dressing was the one placed, dated, and initialed from dayshift on July 9, 2024, and that the previous evening's treatment was not completed as ordered. In an interview on July 11, 2024, at 10:23 a.m., the Director of Nursing confirmed that the wound care had not been completed on the evening shift of July 9, 2024, as per the physician order. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 17709 Based on observation and staff interview, it was determined that the facility failed to post accurate daily nurse staffing information. Findings include: Observation on July 9, 2024, at 8:30 a.m., 10:30 a.m., and 11:00 a.m., revealed that the posted nurse staffing information was from the day before, July 8, 2024. In an interview on July 11, 2024, at 9:30 a.m., the Director of Nursing stated that on the morning of July 9, 2024, the nurse staffing information had not been posted for the correct date. 28 Pa. Code 201.18(b)(3) Management.