STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395636	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at St Luke Village,the	1711 East Broad Street 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 provide nursing services consistent with professional standards of practice by failing to monitor, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice for one resident out of six sampled residents (Resident CR1). 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 resident's 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. Proper documentation and care planning ensure: Monitoring for Symptoms: Identifying signs of device-related complications. Timely Intervention: Staff can promptly address concerns or escalate issues to a physician. Comprehensive Care: Avoiding complications, such as infections at the implant site, through routine assessments and interventions. A review of the clinical record revealed that Resident CR1 was admitted to the facility on [DATE], with diagnoses including liver cirrhosis (chronic liver damage from various causes leading to scarring and liver failure) and chronic ascites (abdominal swelling caused by fluid accumulation, most often related to liver disease). (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Minimum Data Set (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 25, 2025, revealed that Resident CR1 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status a tool within the Cognitive Section of the MDS that assesses the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of a facility policy titled Abdominal or Pleural Intermittent Drainage, last reviewed by the facility on January 23, 2025, required staff to document the condition of the drain site and catheter. Resident CR1 had a left-side thoraco-abdominal drain (a tube inserted to drain fluid from the chest and abdominal cavities) upon admission and underwent an outpatient procedure for placement of a right tunneled peritoneal catheter (a flexible tube inserted into the abdominal cavity to drain excess fluid) on May 12, 2025, while residing at the facility. A review of outpatient interventional radiology (IR) records, provided at the request of the surveyor, showed that after placement of the right tunneled peritoneal catheter, the resident required drainage every other and to call the IR department for any questions, in which a phone number was provided. However, an interview with the Director of Nursing (DON) on June 26, 2025, at 1:00PM, revealed the facility did not have post-procedure care instructions because the family had taken them, and the facility failed to contact the IR department to obtain them. Resident CR1 was sent to the emergency room after this procedure and admitted to the hospital on [DATE], and was re-admitted to the facility on [DATE]. A review of the resident's care plan at discharge and the baseline care plan completed at readmission on [DATE], revealed no specific identification of the right tunneled peritoneal catheter or instructions for its care, including frequency of drainage. The baseline care plan only referenced abdominal drains in general and did not distinguish the two separate sites. A review of physician's orders failed to show any orders for care or monitoring of the newly placed right tunneled peritoneal catheter. A readmission assessment dated [DATE], noted the presence of a right lower quadrant drain site covered by a surgical dressing. Further review of the readmission assessment revealed a nurse's note that stated Resident CR1 had abdominal drain sites on the left upper quadrant and the right lower quadrant, and that the resident stated the right lower surgical dressing cannot be removed until the follow-up appointment, but no follow-up appointment was documented. An interview with the DON confirmed the facility did not inquire about or schedule any follow-up appointment. A review of a change in condition assessment for Resident CR1, dated May 15, 2025, indicated that the resident had a recent hospitalization for a drain repair; however, this documentation was inaccurate, as the hospitalization was for placement of a new right tunneled peritoneal catheter (a flexible tube inserted into the abdominal cavity to drain excess fluid). The same assessment noted that Resident CR1 had a left-side thoraco-abdominal drain (a tube inserted to drain fluid from the chest and abdominal cavities) which was drained for approximately 1000 milliliters every Monday, Thursday, and as needed. The assessment did not include any information about the newly placed right tunneled peritoneal catheter or how often it should be drained. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a skin evaluation completed before discharge, dated May 18, 2025, showed no documentation acknowledging the presence of the right tunneled peritoneal catheter. A review of Resident CR1's progress notes likewise revealed no entries describing the right tunneled peritoneal catheter, its care, or monitoring. A review of Medication Administration Records and Treatment Administration Records revealed no documentation related to Resident CR1's right tunneled peritoneal catheter or monitoring. Resident CR1 was sent to the hospital on May 18, 2025, for worsening jaundice (condition marked by yellowing of the skin and eyes caused by increased bilirubin in the blood) and was admitted for sepsis (a life-threatening response to infection) and a mucus plug in the bronchi (airways in the lungs). In an interview conducted on June 26, 2025, at approximately 2:00 P.M., the Nursing Home Administrator and Director of Nursing (DON) reviewed the information outlined above with the surveyor. During this interview, it was discussed that the facility did not provide evidence of continued monitoring of Resident CR1's right tunneled peritoneal catheter, did not obtain appropriate physician orders, and did not implement a care plan to address the catheter. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.5(f) Medical records.