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	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at St Luke Village,the	1711 East Broad Street 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 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. 48276 Based on a review of grievances filed with the facility and minutes from resident group meetings, and resident, family, and staff interviews, it was determined that the facility failed to provide care in a manner and environment that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two out of the 23 residents sampled (Residents 88 and 298) and three out of 10 residents interviewed during a group interview (Residents 23, 30, and 64). Findings include: A review of grievances filed with the facility revealed a grievance dated March 9, 2024, indicating that Resident 199 was not offered a shower because facility staff told her that they were too short {of staff} to give her a shower. Resident Council Meeting minutes dated April 9, 2024, revealed that the Director of Nursing (DON) explained to residents in attendance that they are trying to find workers to hire. Residents in attendance indicated that they had concerns about needing more help in the facility to provide their care. Resident Council Meeting minutes dated May 7, 2024, revealed that the DON explained to residents that there will be a nurse aide class beginning next month and that three new nurse aides were hired to increase facility staffing. During an interview on May 28, 2024, at 12:10 PM, Resident 88 stated that she sometimes waits 30 minutes for staff to respond when she rings her call bell for staff assistance. The resident explained that the wait time is longer on the weekends. Resident 88 stated that she ends up soiling herself when staff are not able to respond promptly. Resident 88 further explained that the facility staff are nice and work hard, but when there is only one person assigned to her hall, then that person can't help everyone. (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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(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	During an interview on May 28, 2024, at 12:15 PM, Resident 88's family member explained that he is upset that there is not enough staff working in the facility to properly care for his family member. The family member stated that until hospice services began for Resident 88 on March 25, 2024, the facility staff would often leave her in bed until 11:00 AM or later. He explained that she was in bed until 2:00 PM on a few occasions. The family member explained that now that staff from the hospice agency are coming daily Monday through Friday, the hospice staff get her out of bed each morning. He stated that the lack of care is likely because of the low nurse staffing in the facility. The family member stated that he believes his mother developed a pressure injury because of the lack of care by the facility. He explained that she never had bed sores in the past, but she had been lying in bed for hours at the facility. During an interview on May 28, 2024, at 12:30 PM, Resident 298 stated that she had been in the facility for only a few days. She explained that sometimes she is in pain and needs the staff's assistance. Resident 298 stated that she has stopped ringing the call bell because it takes at least 20 minutes for staff to respond to her request for assistance. During a resident group interview with alert and oriented residents, on May 29, 2024, at 10:00 AM, all residents in attendance indicated that the facility doesn't have enough staff to take care of the residents and meet their needs timely. The residents explained that when the facility is short on staff, residents experience long waits for care and assistance. The residents stated that this has been discussed at resident group meetings with no resolution to date. During a resident group interview on May 29, 2024, at 10:00 AM, Resident 23 stated that there is often only one nurse aide working on her hall. She explained that she had recently waited over an hour for staff to provide her care after she rings her call bell. She explained that she is frustrated and angry that no one in the facility addresses this issue. During a resident group interview on May 29, 2024, at 10:00 AM, Resident 30 stated that she has recently waited one hour for staff assistance and has waited as long as two hours within the last two weeks. She explained that sometimes there is only one staff member assigned to her hall, causing long waits for care. Resident 30 explained that she and her husband are both dependent on staff for their care. She indicated that she attempts to help her husband because she does not like to see him waiting for assistance, even though she knows it is not safe for her to do so. During the resident group interview on May 29, 2024, at 10:00 AM, Resident 64 stated that he has soiled himself because the staff response is longer than his body is able to wait. During an interview on May 31, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) and DON verified that all residents at the facility should be treated with dignity and respect, including timely staff responses to residents' requests for assistance. Refer F686 and F725 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on clinical record review, resident and staff interview, it was determined the facility failed to ensure that in preparation for a room change each resident/resident representative received written notice, including the reason for the change before the resident's room was changed for one out of 23 sampled (Resident 89). Findings include: Federal regulatory guidance under S483.10(e)(6) notes that moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. A review of Resident 89's clinical record revealed admission to the facility on [DATE], with diagnoses including gastro-esophageal reflux disease (GERD), diabetes, and heart failure. A review of Resident 89's clinical record, profile, revealed a responsible party (RP), emergency contact # 1, and next of kin, a brother. Emergency contact # 2, substitute decision maker was identified as relationship as other, and Resident 89, self, as no contact type assigned. During interview with alert and oriented Resident 89 on May 30, 2024, at approximately 9:05 AM, the resident stated that some time ago, he had an incident that while lying in bed he was experiencing knee pain. While waiting for the nurse to get him Tylenol, his roommate (Resident 13) came over, without permission, and inappropriately began rubbing - massaging his knee. According to Resident 89, his roommate (Resident 13), then began moving his hands up his leg towards his groin area, making him feel uncomfortable, uneasy. Upon further questioning, Resident 89 stated he did not tell the staff about the incident. However, he further stated that a staff member approached him, and stated that they will be moving his room because the police are going to arrest his roommate (Resident 13). A review of the resident's clinical record revealed that Resident 89's room was changed April 30, 2024. A review of a nursing progress note dated April 30, 2024, at 9:30 AM, indicated interdisciplinary care plan team met to review the resident's plan of care and to continue current plan. A SPN/skilled note dated May 1, 2024, at 1357 (1:57 PM), included a brief statement that the resident is adjusting well to new room. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Social Services on May 30, 2024, at approximately 11:35 AM, she stated that earlier that morning (April 30, 2024) Resident 89 had told her that he awoke and found his roommate (Resident 13), sitting next to his bed, in a chair, staring at him. Resident 89 further stated that made him feel uncomfortable, uneasy. According to the Director of Social Services, there is no documentation regarding this interaction with Resident 89, and regarding the reason for the room change. During interview with the Nursing Home Administrator (NHA) on May 30, 2024, at approximately 1:55 PM the NHA confirmed there is no additional information regarding the room change, and that the facility did not provide any written explanation of the reasons for this move to the resident and/their representative. Refer F 657, F 745 28 Pa Code 201.29 (a) Resident Rights

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 48276 Based on a clinical record review and staff interview, it was determined that the facility failed to ensure that the necessary resident information was communicated to the receiving health care provider for one resident out of 23 residents sampled with facility-initiated transfers (Residents 21). The findings include: A review of Resident 21's clinical record revealed that the resident was transferred to the hospital on December 13, 2023. There was no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, including contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, and any other documentation, as applicable, to ensure a safe and effective transition of care. A review of Resident 21's clinical record revealed that the resident was transferred to the hospital on March 15, 2024. There was no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, including contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and any other documentation, as applicable, to ensure a safe and effective transition of care. During an interview on May 31, 2024, at approximately 11:30 AM, the Director of Nursing (DON) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider for Resident 21's facility-initiated transfers on December 13, 2023 or March 15, 2024. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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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. 48276 Based on review of clinical records and transfer notices, and staff interviews, it was determined that the facility failed to provide written notices of facility-initiated transfers to the resident and the resident's representative as soon as practicable for one out of the 23 residents reviewed (Residents 21). Findings include: A review of the clinical record of Resident 21 revealed the resident was transferred to a community hospital on December 11, 2023. A clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 21 or her resident representative regarding her transfer to the hospital on December 11, 2023. A review of the clinical record of Resident 21 revealed the resident was transferred to the hospital on March 15, 2024. A clinical record review revealed no documented evidence that a notice of transfer or discharge letter was provided to Resident 21 or her resident representative regarding her transfer to the hospital on March 15, 2024. During an interview on May 31, 2024, at approximately 11:30 AM, the Nursing Home Administrator and Director of Nursing confirmed that the facility had no documented evidence that Resident 21 or her resident representative were provided written notices for the facility-initiated transfers on December 11, 2023, or March 15, 2024. 28 Pa. Code 201.29 (a)(c.3)(2) Resident rights

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on review of clinical records, the Resident Assessment Instrument, and staff interview, it was determined that the facility failed to ensure the Minimum Data Set Assessments (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of the 23 sampled (Resident 21). Findings include: A review of Resident 21's quarterly MDS assessment dated [DATE] revealed in Section I Active Diagnoses that Resident 21 has a Multidrug Resident Organism (MDRO- an organism that is resistant to one or more antimicrobial drugs). However, a clinical record review revealed no evidence that Resident 21 had an acute or colonized MDRO. During an interview on May 30, 2024, at approximately 10:30 AM, the Director of Nursing (DON) confirmed that Resident 21 did not have an acute or colonized MDRO. The DON indicated that the MDS entry was an error.

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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** 39235 Based on review of clinical records and staff interview, it was determined that the facility failed to revise a comprehensive care plan in response to potential inappropriate behavior displayed by one resident out of 23 reviewed (Resident 13). Findings include: Review of the clinical record of Resident 13 revealed initial admission to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD), and diabetes. A Social Service Progress note dated March 25, 2024, at 1537 hours (3:37 PM), revealed that the social service staff member spoke with Resident 13 along with the Nursing Home Administrator (NHA), regarding another his roommate's (Resident 49) account that this resident (Resident 13) touched his (Resident 49) leg when he did not want him to. Resident 13, verbalized understanding of appropriate versus inappropriate touch and he denied that he touched anyone in this way. Resident 13 stated he feels safe here and has no concern. Will continue to monitor A review of information dated March 25, 2024, submitted by the facility revealed that Resident 49 alleged his roommate (resident 13) touches him inappropriately while he sleeps. Responsible party (RP), MD, AAA, police notified, Act 13 sent. A review of Resident 13's current care plan revealed a focused area of mood problems related to depression, tearful/sad, related to partner and housing situation, insomnia, date revised April 22, 2024. Interventions included to administer medications as ordered and monitor for side effects, see physician orders, medication administration records (MARs) date revised March 21, 2023, assist resident in developing/providing program of activities, identify strengths, positive coping skills, behavioral health consults as needed, educate on expectations of treatment and side effects, monitor for risk for harm to self, monitor mood, and report to MD mood patterns, acute episode feelings or sadness, depression, risk of harming others, and encourage need to express feelings, date initiated February 24, 2023. There was no documented evidence that Resident 13's care plan had been reviewed and revised related to his roommate's allegation unwelcome touching and need for continued monitoring for this potential behavior as noted in the Social Service Progress note dated March 25, 2024, which was confirmed during interview with the . the Director of Nursing (DON) on May 30, 2024, at approximately 2:10 PM. Refer F 559, F 745 28 Pa. Code 211.12 (d)(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** 48276 Based on a review of clinical records, select facility policy, and facility investigation reports, observation, and resident, staff, and resident family member interviews, it was determined that the facility failed to ensure that residents receive care consistent with professional standards of practice to prevent pressure sore development for one of 23 residents sampled (Resident 88). Findings include: A review of facility policy titled Skin and Wound, last reviewed by the facility on March 25, 2024, revealed it is the facility's policy to provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries. A clinical record review revealed Resident 88 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and acute kidney failure (kidneys are suddenly not able to filter waste products from the blood). A baseline care plan dated February 19, 2024, indicated that Resident 88 has the potential for altered skin integrity, with a goal to prevent a skin breakdown or injury. The plan included an intervention to turn the resident every two hours and as needed, provide incontinence care as needed, apply preventative skin care each shift and as needed, apply barrier incontinence cream each shift and as needed, and report any skin breakdown to the charge nurse. A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 21, 2024, revealed that Resident 88 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). Resident 88 was dependent on staff to roll from lying on the back to the left and right sides, to move from a sitting position to lying on the bed, to stand from a sitting position, to transfer to and from a bed to a chair, and to get in and out of a tub or shower. A Braden Scale for Predicting Pressure Sore {Ulcer} Risk dated February 26, 2024, indicated that Resident 88 was assessed and found to be at risk of developing pressure injuries. Braden Scale for Predicting Pressure Sore {Ulcer} Risk dated March 11, 2024, indicated that Resident 88 was assessed and found to be not at risk of developing pressure injuries. The assessment indicated that Resident 88 was rarely moist (skin is usually dry) and walked occasionally (walks during the day, but for very short distances). However, a review of the survey documentation reports dated February 2024 and March 2024 revealed that from February 19, 2024, through March 11, 2024, Resident 88 walked on only four out of 66 shifts and was found to be incontinent of urine 26 times from February 19, 2024, through March 11, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A documentation survey report for March 2024 indicated that staff did not turn and reposition Resident 88 every two hours as indicated in her baseline care plan. The report indicated that turning and repositioning began on March 18, 2024, the date the resident was first assessed to have a pressure injury. The medical record failed to indicate if staff turned or repositioned the resident every two hours prior to the resident developing a pressure injury on March 18, 2024. A pressure ulcer wound round document dated March 18, 2024, revealed that the resident was assessed to have an unstageable pressure ulcer wound on her coccyx measuring 3.0 cm x 2.0 cm x 0.2 cm. The assessment indicated that an unstageable pressure injury is full-thickness tissue loss in which the base of the ulcer is covered by slough (dead skin tissue that is yellow, tan gray, green, or brown) and/or eschar (dead tissue that is tan, brown, or black) in the wound bed. The assessment further noted that the wound was not present on admission. The wound bed was observed to have a yellow slough. The wound edges were rolled. The assessment indicated that the wound had a small amount of serous drainage. Furthermore, the assessment indicated that the wound began as two scratch-like areas that combined and opened the coccyx area. A review of pressure ulcer wound round documentation revealed the following progress of the resident's coccyx wound: On March 18, 2024, the wound measured 3.0 cm x 2.0 cm x 0.2 cm. On March 20, 2024, the wound measured 2.2 cm x 1.5 cm x 2.0 cm. On March 27, 2024, the wound measured 2.3 cm x 1.5 cm x 2.0 cm. On April 3, 2024, the wound measured 2.5 cm x 2.0 cm x 2.0 cm. On April 10, 2024, the wound measured 2.5 cm x 2.0 cm x 2.0 cm. On April 17, 2024, the wound measured 2.5 cm x 2.0 cm x 2.0 cm. On April 24, 2024, the wound measured 3.5 cm x 2.5 cm x 3.8 cm. On May 1, 2024, the wound measured 2.8 cm x 3.0 cm x 3.3 cm. On May 8, 2024, the wound measured 2.1 cm x 1.4 cm x 0.8 cm. On May 15, 2024, the wound measured 2.5 cm x 1.5 cm x 0.7 cm On May 22, 2024, the wound measured 1.7 cm x 1.0 cm x 0.3 cm. On May 29, 2024, the wound measured 1.5 cm x 1.0 cm x 0.3 cm. A physician's order for Resident 88 to be admitted to Hospice Services related to a diagnosis of heart failure dated March 25, 2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 28, 2024, at 12:10 PM, Resident 88 was not able to recall staff turning or repositioning her during her first month of admission. Resident 88 stated that she sometimes waits 30 minutes for staff to respond when she rings her call bell for assistance. The resident explained that the wait time is longer on the weekends. Resident 88 stated that she ends up soiling herself when staff are not able to respond. During an interview on May 28, 2024, at 12:15 PM, Resident 88's family member explained that Resident 88 was not being turned or repositioned by staff regularly from the time of admission until the development of her pressure injury. He explained that he was upset that there were not enough facility staff to properly care for his family member. The family member stated that before hospice services began providing care to Resident 88 on March 25, 2024, the facility would often leave her in bed until 11:00 AM or later. The family member explained that now, hospice services are coming daily, Monday through Friday, and the hospice staff get her out of bed each morning. A clinical record review revealed no documentation indicating what time of day Resident 88 was assisted out of bed each morning from her admission on February 19, 2024, until the assessment of an unstageable pressure ulcer wound on her coccyx on March 18, 2024. During an observation on May 30, 2024, at 1:50 PM, the wound was measured at 1.5 cm x 1.0 cm x 0.8 cm. The wound was observed with edges intact, no odor, and no drainage noted. The wound dressing was clean, with no color noted. The resident indicated that she was not experiencing pain related to her injury. During an interview on May 31, 2024, at approximately 11:15 PM, the Director of Nursing and Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that residents receive care consistent with professional standards of practice to prevent pressure injuries and ensure pressure injuries do not develop. The DON or NHA were unable to provide evidence that Resident 88 was turned or repositioned as indicated in her baseline plan of care to prevent the development of pressure injuries. Refer F550 and F725 28 Pa. Code 211.5 (f)(ii)(iii)(iv) Medical records 28 Pa. Code 211.10(d) Resident care policies 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on clinical record review and resident, and staff interview, it was determined that the facility failed to provide restorative nursing services planned to maintain mobility and functional abilities of one of four residents sampled (Resident 75). Findings included: A review of the clinical record of Resident 75 revealed admission to the facility on [DATE], with diagnoses to include reduced mobility, muscle wasting, muscle weakness, and unsteadiness on feet. A physician's order dated was March 22, 2024, for the resident to receive RNP ambulation. During interview with the alert and oriented Resident 75, on May 28, 2024, at approximately 12:45 PM, the resident stated staff are not walking her. Resident 75 further stated she kept track and in the past 29 days she was walked once. The resident further stated she had told staff that she is not being ambulated as ordered and nothing was done about it. A review of Resident 75's Physical Therapy Discharge Summary dated April 29, 2024, indicated that the resident was receiving services from March 12, 2024, to April 24, 2024, and that the discharge recommendations were to receive Restorative Nursing Program (RNP, with no indication of the specifics of the restorative nursing program. A review of a facility provided document entitled Rehab Services Restorative Nursing/Functional Maintenance Referral form dated April 24, 2024, indicated that the resident was to receive ambulation, to preserve functional mobility skills. Instructions indicated RNP with a restorative nursing assistant (RNA) for ambulation with a wheeled walker (WW) for up to 300 feet contact guard (CG) assist with close wheelchair (WC) follow. A physician orders dated May 23, 2024, was noted for physical therapy (PT) 5X/week for 30 days for gait training, therapeutic exercises, therapeutic activities, neuromuscular re-education. During an interview on May 29, 2024, at approximately 11:45 AM, with the Director of Therapy Services, confirmed Resident 75 should have received RNP, with a restorative nursing assistant for ambulation, from April 24, 2024, through May 23, 2024. A review of the Documentation Survey Report v2 for April 2024, and May 2024, revealed that Resident 75's RNP for ambulation was not implemented, as recommended by in the PT discharge summary, Rehab Services Restorative Nursing/Functional Maintenance Referral, and as prescribed by the physician. Interview with the Director of Nursing (DON) on May 29, 2024, at 12:45 PM failed to provide documented evidence that Resident 75 was provided with the physician prescribed RNP program. 28 Pa. Code: 211.5(f) Clinical records (continued on next page)

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	395636	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manor at St Luke Village,the	1711 East Broad Street Hazleton, PA 18201

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on observations, clinical record review and staff interview it was determined that the facility failed to ensure consistent communication between the facility and dialysis center were completed, including weights and vital signs, and failed to monitor fluid intake for residents prescribed on fluid restrictions for two residents out of 23 residents sampled (Residents 76 and 54). Findings include: A review of a facility policy entitled Coordination of Hemodialysis Services that was last reviewed by the facility on January 25, 2024, indicated that residents requiring an outside End Stage Renal Disease [(ESRD) is a condition where the kidney reaches advanced state of loss of function. This causes changes in urination, fatigue, swelling of feet, high blood pressure, and loss of appetite] facility would have services coordinated by the facility and that there would be communication between the facility and ESRD facility regarding the resident. The Dialysis Communication form would be initiated by the facility for any resident going to an ESRD center for hemodialysis [a procedure where a dialysis machine and a special filter called an artificial kidney, or a dialyzer, are used to clean blood]. Nursing will collect and complete the information regarding the resident and send to the ESRD Center. Upon the resident's return to the facility, nursing would review the Dialysis Communication form and communicate with the resident's physician and other ancillary department as needed and implement interventions as appropriate. Nursing will complete the post dialysis information on the Dialysis Communication form and file the completed form in the resident's clinical record. The facility policy entitled Fluid Restrictions that was last reviewed by the facility on January 25, 2024, indicated that the Care Planning Team will discuss the restrictions, and would be included in the care plan. The dietitian documents the allowed fluids in the medical record and provide a written breakdown of fluids to nursing staff. The attending physician will be notified of resident choice not to adhere to restrictions. A review of Resident 76's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included ESRD and required hemodialysis treatments three times per week. A physician's order was dated November 26, 2023, for dialysis treatments three times per week on Monday, Wednesday, and Friday and an order for a 1,000 cc's fluid restriction [limits the amount of daily fluid consumption to help avoid fluid overload (build-up of fluid] per day. A review of Resident 76's plan of care that was last revised on April 15, 2024, indicated that the resident required dialysis related to renal failure and would not have any signs or symptoms of complications from dialysis. Planned interventions included to communicate with dialysis facility as needed, monitor resident treatment records from dialysis center, 1,000 ml per 24-hour fluid restriction, and 600 cc's from dietary and 400 cc's from nursing. Review of Resident 76's Medication Administration Record dated January 2024 through May 31, 2024, revealed that the facility was not monitoring the total amount of fluids that the resident was consuming from meals and medications. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's Survey Documentation Report [an electronic record that summarizes planned resident centered tasks and care completed by nurse aides] dated January 2024 through May 31, 2024, revealed that fluid consumption was not consistently recorded. Resident 76's clinical record failed to reveal that staff were consistently and accurately recording and monitoring the physician's prescribed fluid restriction and unable to determine the actual amount of fluids consumed. The resident's plan of care failed to indicate the amount of fluids that would be provided at meals and snacks. A review of Resident 76's Dialysis Communication forms April 2024 through May 31, 2024, revealed that there were no post dialysis weights recorded. The facility failed to provide documented evidence that post dialysis/dry weights were obtained to ensure that Resident 76 medical status was monitored for potential complications post treatments. A review of Resident 54's clinical record revealed that the resident was readmitted to the facility was on January 2, 2024, with diagnoses that ESRD and receiving hemodialysis, and dementia [is the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities]. A physician's order dated January 3, 2024, was noted for dialysis treatments three times per week on Monday, Wednesday, and Friday and an order for a 1,500 cc's fluid restriction [limits the amount of daily fluid consumption to help avoid fluid overload (build-up of fluid] per day. Resident 54's plan of care that was last revised on April 23, 2024, indicated that the resident required dialysis related to renal failure and would not have any signs or symptoms of complications from dialysis. Planned interventions included to communicate with dialysis facility as needed, monitor resident treatment records from dialysis center, 1,500 ml per 24-hour fluid restriction, 260 cc's from nursing every shift. Review of Resident 54's Medication Administration Record dated January 2024 through May 31, 2024, revealed that the facility was not monitoring the total amount of fluids that the resident was consuming from meals and medications. The Survey Documentation Report dated January 2024 through May 31, 2024, revealed that fluid consumption was not consistently recorded. Resident 54's clinical record failed to reveal that staff were consistently and accurately recording and monitoring the physician's prescribed fluid restriction and unable to determine the actual amount of fluids consumed. The resident's plan of care failed to indicate the amount of fluids that would be provided at meals and snacks. A review of Resident 54's Dialysis Communication forms April 2024 through May 31, 2024, revealed that there were no post dialysis weights recorded. The facility failed to provide documented evidence that post dialysis/dry weights were obtained to ensure that Resident 54's medical status was monitored for potential complications post treatments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Employee 1, Registered Nurse Supervisor, on May 29, 2024, at 10:35 a.m., revealed that each dialysis resident had a Dialysis Communication form that should have a recorded pre and post dialysis weight. Employee 1 reported that post weights for dialysis residents were not being consistently obtained at the dialysis treatment center and that facility staff didn't follow-up with the center to ensure a weight was collected and entered into the resident's clinical record for post dialysis monitoring. The facility was unable to provide documented evidence that the facility ensured that Resident 76's and Resident 54's physician prescribed fluid restriction or fluid intakes were accurately recorded or monitored. Interview with the Director of Nursing (DON) on May 31, 2024, at 10:30 a.m., confirmed that the facility failed to accurately document fluid intakes for residents ordered on fluid restrictions and failed to provide documented evidence post dialysis weights were obtained, recorded, and monitored for Residents 76 and 54. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services 28 Pa. Code 211.10 (a)(c)(d) Resident care policies

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on a review of nurse staffing, clinical records, grievances lodged with the facility and the minutes from Residents Council meetings and staff, resident and family interviews, it was determined that the facility failed to provide sufficient nursing staff to provide timely and quality of care to residents, and in accordance with each resident's plan of care, to meet individualized needs and promote the resident's health and well-being. Findings included: A review of grievances filed with the facility revealed a grievance dated March 9, 2024, indicating that Resident 199 was not offered a shower because facility staff told her that they were too short {of staff} to give her a shower. Resident Council Meeting minutes dated April 9, 2024, revealed that the Director of Nursing (DON) explained to residents in attendance that they are trying to find workers to hire. Residents in attendance indicated that they had concerns about needing more help in the facility to provide their care. Resident Council Meeting minutes dated May 7, 2024, revealed that the DON explained to residents that there will be a nurse aide class beginning next month and that three new nurse aides were hired to increase facility staffing. During an interview on May 28, 2024, at 12:10 PM, Resident 88 stated that she sometimes waits 30 minutes for staff to respond when she rings her call bell for staff assistance. The resident explained that the wait time is longer on the weekends. Resident 88 stated that she ends up soiling herself when staff are not able to respond promptly. Resident 88 further explained that the facility staff are nice and work hard, but when there is only one person assigned to her hall, then that person can't help everyone. During an interview on May 28, 2024, at 12:15 PM, Resident 88's family member explained that he is upset that there is not enough staff working in the facility to properly care for his family member. The family member stated that until hospice services began for Resident 88 on March 25, 2024, the facility staff would often leave her in bed until 11:00 AM or later. He explained that she was in bed until 2:00 PM on a few occasions. The family member explained that now that staff from the hospice agency are coming daily Monday through Friday, the hospice staff get her out of bed each morning. He stated that the lack of care is likely because of the low nurse staffing in the facility. The family member stated that he believes his mother developed a pressure injury because of the lack of care by the facility. He explained that she never had bed sores in the past, but she had been lying in bed for hours at the facility. During an interview on May 28, 2024, at 12:30 PM, Resident 298 stated that she had been in the facility for only a few days. She explained that sometimes she is in pain and needs the staff's assistance. Resident 298 stated that she has stopped ringing the call bell because it takes at least 20 minutes for staff to respond to her request for assistance. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a resident group interview with alert and oriented residents, on May 29, 2024, at 10:00 AM, all residents in attendance indicated that the facility doesn't have enough staff to take care of the residents and meet their needs timely. The residents explained that when the facility is short on staff, residents experience long waits for care and assistance. The residents stated that this has been discussed at resident group meetings with no resolution to date. During a resident group interview on May 29, 2024, at 10:00 AM, Resident 23 stated that there is often only one nurse aide working on her hall. She explained that she had recently waited over an hour for staff to provide her care after she rings her call bell. She explained that she is frustrated and angry that no one in the facility addresses this issue. During a resident group interview on May 29, 2024, at 10:00 AM, Resident 30 stated that she has recently waited one hour for staff assistance and has waited as long as two hours within the last two weeks. She explained that sometimes there is only one staff member assigned to her hall, causing long waits for care. Resident 30 explained that she and her husband are both dependent on staff for their care. She indicated that she attempts to help her husband because she does not like to see him waiting for assistance, even though she knows it is not safe for her to do so. During the resident group interview on May 29, 2024, at 10:00 AM, Resident 64 stated that he has soiled himself because the staff response is longer than his body is able to wait. During an interview on May 31, 2024, at approximately 11:30 AM, the Nursing Home Administrator (NHA) and DON verified that all residents at the facility should be treated with dignity and respect, including timely staff responses to residents' requests for assistance. A clinical record review revealed Resident 88 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and acute kidney failure (kidneys are suddenly not able to filter waste products from the blood). A baseline care plan dated February 19, 2024, indicated that Resident 88 has the potential for altered skin integrity, with a goal to prevent a skin breakdown or injury. The plan included an intervention to turn the resident every two hours and as needed, provide incontinence care as needed, apply preventative skin care each shift and as needed, apply barrier incontinence cream each shift and as needed, and report any skin breakdown to the charge nurse. A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 21, 2024, revealed that Resident 88 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). Resident 88 was dependent on staff to roll from lying on the back to the left and right sides, to move from a sitting position to lying on the bed, to stand from a sitting position, to transfer to and from a bed to a chair, and to get in and out of a tub or shower. A Braden Scale for Predicting Pressure Sore {Ulcer} Risk dated February 26, 2024, indicated that Resident 88 was assessed and found to be at risk of developing pressure injuries. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Braden Scale for Predicting Pressure Sore {Ulcer} Risk dated March 11, 2024, indicated that Resident 88 was assessed and found to be not at risk of developing pressure injuries. The assessment indicated that Resident 88 was rarely moist (skin is usually dry) and walked occasionally (walks during the day, but for very short distances). However, a review of the survey documentation reports dated February 2024 and March 2024 revealed that from February 19, 2024, through March 11, 2024, Resident 88 walked on only four out of 66 shifts and was found to be incontinent of urine 26 times from February 19, 2024, through March 11, 2024. A documentation survey report for March 2024 indicated that staff did not turn and reposition Resident 88 every two hours as indicated in her baseline care plan. The report indicated that turning and repositioning began on March 18, 2024, the date the resident was first assessed to have a pressure injury. The medical record failed to indicate if staff turned or repositioned the resident every two hours prior to the resident developing a pressure injury on March 18, 2024. A pressure ulcer wound round document dated March 18, 2024, revealed that the resident was assessed to have an unstageable pressure ulcer wound on her coccyx measuring 3.0 cm x 2.0 cm x 0.2 cm. The assessment indicated that an unstageable pressure injury is full-thickness tissue loss in which the base of the ulcer is covered by slough (dead skin tissue that is yellow, tan gray, green, or brown) and/or eschar (dead tissue that is tan, brown, or black) in the wound bed. The assessment further noted that the wound was not present on admission. The wound bed was observed to have a yellow slough. The wound edges were rolled. The assessment indicated that the wound had a small amount of serous drainage. Furthermore, the assessment indicated that the wound began as two scratch-like areas that combined and opened the coccyx area. A physician's order for Resident 88 to be admitted to Hospice Services related to a diagnosis of heart failure dated March 25, 2024. During an interview on May 28, 2024, at 12:10 PM, Resident 88 was not able to recall staff turning or repositioning her during her first month of admission. Resident 88 stated that she sometimes waits 30 minutes for staff to respond when she rings her call bell for assistance. The resident explained that the wait time is longer on the weekends. Resident 88 stated that she ends up soiling herself when staff are not able to respond. During an interview on May 28, 2024, at 12:15 PM, Resident 88's family member explained that Resident 88 was not being turned or repositioned by staff regularly from the time of admission until the development of her pressure injury. He explained that he was upset that there were not enough facility staff to properly care for his family member. The family member stated that before hospice services began providing care to Resident 88 on March 25, 2024, the facility would often leave her in bed until 11:00 AM or later. The family member explained that now, hospice services are coming daily, Monday through Friday, and the hospice staff get her out of bed each morning. A clinical record review revealed no documentation indicating what time of day Resident 88 was assisted out of bed each morning from her admission on February 19, 2024, until the assessment of an unstageable pressure ulcer wound on her coccyx on March 18, 2024. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on May 30, 2024, at 1:50 PM, the wound was measured at 1.5 cm x 1.0 cm x 0.8 cm. The wound was observed with edges intact, no odor, and no drainage noted. The wound dressing was clean, with no color noted. The resident indicated that she was not experiencing pain related to her injury. During an interview on May 31, 2024, at approximately 11:15 PM, the Director of Nursing and Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that residents receive care consistent with professional standards of practice to prevent pressure injuries and ensure pressure injuries do not develop. The DON or NHA were unable to provide evidence that Resident 88 was turned or repositioned as indicated in her baseline plan of care to prevent the development of pressure injuries. A review of the clinical record of Resident 75 revealed admission to the facility on [DATE], with diagnoses to include reduced mobility, muscle wasting, muscle weakness, and unsteadiness on feet. A physician's order dated was March 22, 2024, for the resident to receive RNP ambulation. During interview with the alert and oriented Resident 75, on May 28, 2024, at approximately 12:45 PM, the resident stated staff are not walking her. Resident 75 further stated she kept track and in the past 29 days she was walked once. The resident further stated she had told staff that she is not being ambulated as ordered and nothing was done about it. A review of Resident 75's Physical Therapy Discharge Summary dated April 29, 2024, indicated that the resident was receiving services from March 12, 2024, to April 24, 2024, and that the discharge recommendations were to receive Restorative Nursing Program (RNP, with no indication of the specifics of the restorative nursing program. A review of a facility provided document entitled Rehab Services Restorative Nursing/Functional Maintenance Referral form dated April 24, 2024, indicated that the resident was to receive ambulation, to preserve functional mobility skills. Instructions indicated RNP with a restorative nursing assistant (RNA) for ambulation with a wheeled walker for up to 300 feet contact guard (CG) assist with close wheelchair (WC) follow. A physician orders dated May 23, 2024, was noted for physical therapy (PT) 5X/week for 30 days for gait training, therapeutic exercises, therapeutic activities, neuromuscular re-education. During an interview on May 29, 2024, at approximately 11:45 AM, with the Director of Therapy Services, confirmed Resident 75 should have received RNP, with a restorative nursing assistant for ambulation, from April 24, 2024, through May 23, 2024. A review of the Documentation Survey Report v2 for April 2024, and May 2024, revealed that Resident 75's RNP for ambulation was not implemented, as recommended by in the PT discharge summary, Rehab Services Restorative Nursing/Functional Maintenance Referral, and as prescribed by the physician. Interview with the Director of Nursing (DON) on May 29, 2024, at 12:45 PM failed to provide documented evidence that Resident 75 was provided with the physician prescribed RNP program. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's staffing levels revealed that on the following dates the facility failed to provide state minimum nurse staffing of 2.87 hours of general nursing care to each resident: March 21, 2024 - 2.46 direct care nursing hours per resident March 22, 2024 - 2.39 direct care nursing hours per resident March 23, 2024 - 2.30 direct care nursing hours per resident March 24, 2024 - 2.33 direct care nursing hours per resident March 25, 2024 - 2.39 direct care nursing hours per resident March 26, 2024 - 2.51 direct care nursing hours per resident March 27, 2024 - 2.82 direct care nursing hours per resident March 31, 2024 - 2.24 direct care nursing hours per resident April 1, 2024 - 2.72 direct care nursing hours per resident April 2, 2024 - 2.64 direct care nursing hours per resident April 3, 2024 - 2.79 direct care nursing hours per resident April 4, 2024 - 2.84 direct care nursing hours per resident April 5, 2024 - 2.81 direct care nursing hours per resident April 6, 2024 - 2.55 direct care nursing hours per resident May 24, 2024 - 2.45 direct care nursing hours per resident May 25, 2024 - 2.35 direct care nursing hours per resident May 26, 2024 - 2.27 direct care nursing hours per resident May 27, 2024 - 2.65 direct care nursing hours per resident May 28, 2024 - 2.48 direct care nursing hours per resident May 29, 2024 - 2.67 direct care nursing hours per resident May 30, 2024 - 2.25 direct care nursing hours per resident An interview with the Director of Nursing (DON) on May 31, 2024, at 12: 30 p.m., confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer F550, F686, F688 28 Pa. Code 211.12 (c)(d)(4)(5)(f.1)(2)(4) Nursing services 28 Pa. Code 201.18 (b)(1)(3)(e)(1)(2)(3)(6) 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** 39235 Based on a review of clinical records and select investigation reports, and staff interview, it was determined that the facility failed to develop and/or implement an individualized person-centered plan to address a resident's dementia-related behavioral symptoms to promote resident safety and highest practicable physical and mental well-being for one out of 23 residents reviewed (Resident 42). Findings include: A review of Resident 42's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), overactive bladder, and myasthenia gravis (a disorder that causes weakness of the skeletal muscles). A review of Resident 42's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 15, 2023, revealed the resident was severely cognitively impaired. The resident displayed multiple behavioral symptoms including physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually); Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others); Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming. Section E, impact on resident, indicated that these behaviors significantly impacted the resident negatively and potentially impacted other residents negatively. Under section E Wandering, it was noted that the resident had wandering behavior 1-3 days during the 7 day look back period. A review of progress notes in the resident's clinical record dated from December 1, 2023, to May 30, 2024, revealed that the resident exhibited behaviors of standing unassisted, falling, wandering, being nasty, argumentative, combative, yelling, smacking/hitting staff, cursing, undressing in public, urinating on floor. A review of facility investigation report entitled fall, dated December 1, 2023, at 1710 hours (5:10 PM), indicated that the resident's chair alarm activated. The resident was found in dining room on floor on her left side. Resident stating she was trying to make it to the bathroom. A review of facility investigation report entitled fall, dated December 30, 2023, at 1932 hours (7:32 PM), indicated that the resident is non-compliant, and ambulates unassisted. Staff found the resident sitting on the floor in the doorway of another resident's room. Resident stated she was looking for a thing from the garden. A review of facility investigation report entitled fall, dated April 20, 2024, at 11:40 AM, revealed that the resident stood up from her wheelchair unassisted. The alarm was sounding, and the resident attempted to walk and fell . Resident stated I had to go to the bathroom. (continued on next page)

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	05/31/2024

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.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility investigation report entitled fall, dated May 4, 2024, at 1415 hours (2:15 PM), revealed that staff observed the laying on the floor in front of the closed bathroom door with a garbage can under her buttocks, and dry brief down at her knees. Resident stated I had to go o the bathroom. Review of Resident 42's current care plan in effect at the time of the survey ending May 31, 2024, revealed a focus area of the resident's behavioral concerns including disrobing, restless, yelling/cursing at staff related to anxiety, and metabolic encephalopathy, date revised April 22, 2024. The interventions planned included to administer medications, anticipate needs, provide positive interaction, attention, intervene as necessary, monitor behavior and attempt to determine cause, and praise in progress, date-initiated October 4, 2023. A review of the resident care plan also revealed a focus area regarding wandering related to attempts to leave the facility unattended date revised April 22, 2024. The interventions planned included to document wandering behavior and attempted diversional intervention, distract resident, change wander guard per protocol, check placement every shift and function daily, identify patterns, provide structured activities, date-revised November 16, 2023. A continued review of resident 42's care plan at the time the survey ending May 31, 2024, failed to identify the resident combative behavior of smacking/hitting staff and the interventions designed for staff to employ to address these physically combative behaviors. There was no documented evidence at the time the survey ending May 31, 2024, to demonstrate that facility had updated the resident's care plan with respect to the interventions/tasks for staff to implement in response to the dementia related behaviors, in an effort to deter, modify or safely manage the behaviors displayed. Interview with the Director of Nursing (DON) on May 30, 2024, at approximately 2:05 PM confirmed the facility failed to identify the resident combative behavior of smacking/hitting staff and or the interventions designed for staff to employ to address these behaviors, and that the facility had not updated the resident's care plan for behaviors from November 2023, to present, with respect to the interventions/tasks, in an effort to deter, modify or safely manage the behaviors displayed, to address the resident's known dementia related behaviors to include standing unassisted, falling, wandering, being nasty, argumentative, combative, yelling, smacking/hitting staff, cursing, undressing in public, urinating on floor. There was no evidence that the facility had developed an interdisciplinary approach to the resident's dementia care and ensured that staff demonstrated the necessary competencies and skills to provide appropriate services to the resident, to include individualized approaches to the resident's care, including direct care and activities. There was no evidence that the facility had attempted to provide meaningful activities, which promote resident engagement based on the resident's customary routines, interests, preferences, to enhance the resident's mental health and well-being. An interview with the Nursing Home Administrator (NHA) on May 30, 2024, at approximately 2:11 PM, confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia-related behaviors. 28 Pa Code 211.12 (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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records, and resident and staff interviews, it was revealed that the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of one resident out of 23 sampled (Resident 89). Findings include: According to regulatory guidance under S483.40(d) Medically-related social services means services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health, which include providing or arranging for needed mental and psychosocial counseling services and identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident. A review of Resident 89's clinical record indicated admission to the facility on [DATE], with diagnosis including gastro-esophageal reflux disease (GERD), diabetes, and heart failure. During interview with alert and oriented Resident 89 on May 30, 2024, at approximately 9:05 AM, the resident stated that some time ago, he had an incident that occurred while he was lying in bed. He was experiencing knee pain and while waiting for the nurse to get him Tylenol, his roommate (Resident 13) came over, without request or permission, and began rubbing - massaging his knee. According to Resident 89, his roommate (Resident 13), then began moving his hands up his leg towards his groin area, making him feel uncomfortable, uneasy. Upon further questioning, Resident 89 stated he did not tell the staff about the incident. However, he further stated that a staff member approached him, and stated that they will be moving his room because the police are going to arrest his then roommate (Resident 13). Resident 89's clinical record revealed that the resident's room was changed on April 30, 2024. A nursing progress note dated April 30, 2024, at 9:30 AM, indicated that the interdisciplinary care plan team met to review plan of care. Continue current plan. A SPN/skilled note dated May 1, 2024, at 1357 (1:57 PM), noted that the resident was adjusting well to new room. During interview with the Director of Social Services on May 30, 2024, at approximately 11:35 AM, she stated that earlier on the morning of April 30, 2024, Resident 89 had told her that he awoke and found his roommate (Resident 13), sitting next to his bed, in a chair, staring at him. Resident 89 further stated that made him feel uncomfortable, uneasy. According to the Director of Social Services, there is no documentation regarding her conversation with Resident 89, or regarding the room change. She was unable to provide documented evidence that she had followed up, or talked with Resident 89 regarding this incident of awakening and finding his roommate (Resident 13), sitting next to his bed, in a chair, staring at him, which caused him to feel uncomfortable, uneasy, causing the facility to change his room. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Nursing (DON) on May 30, 2024, at approximately 2:10 PM the DON confirmed there is no documentation regarding the reason for Resident 89's room change, and that there was no documented evidence of the provision of therapeutic social services provided to Resident 89 following his statement of being made uncomfortable, uneasy, by his roommate's inappropriate touching. Refer F 559, F 657 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.16 (a) Social Services