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	03/28/2025

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51726 Based on a review of facility policy, resident grievance documentation, clinical records, and interviews with residents and staff, it was determined that the facility failed to ensure a thorough and complete investigation of an allegation of sexual abuse for 1 of 19 sampled residents (Resident 63). Findings included: A review of a facility policy entitled Abuse, Neglect, Exploitation & Misappropriation revealed it is the policy of the facility to provide professional care and services in an environment that is free from abuse, neglect, mistreatment, exploitation, and/or misappropriation of property. The facility will follow the federal guidelines dedicated to the prevention of abuse and timely and thorough investigations of allegations. Sexual abuse is defined as the nonconsensual sexual contact of any type with a resident which includes but is not limited to unwanted touching of any kind especially of breast or perineal area. Further review of the facility abuse policy revealed under the area of investigation that the Abuse Coordinator or designee will investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. Upon the allegation of abuse or neglect, the suspect will be immediately segregated from residents pending the investigation of the resident allegation. The nurse or Director of Nursing/designee will perform and document a thorough nursing evaluation and notify the attending physician. An incident report will be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. The Abuse Coordinator and/or Director of Nursing will take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she will also secure all physical evidence. Upon completion of the investigation, a detailed report will be prepared. Under the area of reporting, the facility should report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with state law, including to the State Survey Agency within 5 working days of the incident. A review of Resident 63's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (a condition where the heart does not pump blood as efficiently as it should) and chronic kidney disease (a condition where the kidneys cannot filter blood properly leading to waste buildup). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility grievance dated February 14, 2025, revealed that Resident 63 no longer wanted Employee 1 to care for her because of the way Employee 1 performed peri-care ((perineal care hygiene of the private areas) made Resident 63 uncomfortable. A written statement from the RN on the 11-7 shift dated February 14, 2025, at 12:00 AM, revealed Resident 63 complained of poor care received on the evening shift. It further revealed Resident 63 stated she felt she is being assaulted when she is getting peri care by Employee 1. A written statement from the NHA dated February 14, 2025, at 8:15 AM documented the NHA asking for additional clarification from the RN on the 11-7 shift. The RN reported Resident 63 said specifically, She didn't like how her hands were on her buttocks and that her fingers went into her rectum and that Resident 63 didn't like the way Employee 1 cleaned her up. Upon an interview conducted on March 26, 2025, at approximately 11 AM, Resident 63 indicated, Employee 1 Put her finger up my a** while performing peri care. The Resident denied sexual or physical harm but stated, It was weird, I did not want her doing that to me again or any other resident. During a telephone interview on March 26, 2025, at approximately 12:00 PM, Employee 1 indicated she no longer works at the facility because of group of residents did not like her due to her race. She further stated she would document care given to Resident 63 but did not perform the care because Resident 63 always refused to let her care for her. The Documentation Survey Report v2 for February 2025 indicated Employee 1 rendered personal hygiene care to Resident 63 on the evening shift of February 13, 2025. Despite this allegation meeting the definition of sexual abuse as outlined by both facility policy and federal regulation, the facility failed to demonstrate a thorough and complete investigation as required. The facility did not: Obtain written statements from witnesses or other staff present. Document a comprehensive nursing evaluation. Notify the attending physician. Complete an incident report. Secure physical evidence. Report the results of the investigation to the State Survey Agency within the required 5 working days. In an interview conducted on March 26, 2025, at approximately 12:45 PM, the NHA and DON acknowledged they were unable to provide evidence that the abuse investigation was completed in response to the resident's allegation. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29(a)(c) Resident Rights

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for one of 19 residents reviewed (Resident 58) to reflect the resident's discharge goals. Findings Include: Clinical record review revealed that Resident 58 was admitted to the facility on [DATE], with diagnoses to include Dysarthria (the muscles used for speech are weak or are hard to control. Dysarthria often causes slurred or slow speech that can be difficult to understand) following a cerebral infraction (stroke). Review of a significant change Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated March 2, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 indicating he was cognitively intact. A review of Resident 58's social service notes revealed no social service notes in regard to discharge planning. Resident 58's clinical record did reveal a psychiatry consult dated January 27, 2025 indicating the resident wanted to discharge from the facility. There was no further documentation in Resident 58's clinical record regarding discharge planning. A review of the resident's comprehensive care plan, reviewed during the survey ending March 28, 2025, revealed no documented evidence that an individualized discharge plan was developed, and revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Nursing Home Administrator on March 27, 2025, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident. 28 Pa. Code 201.18(b)(1) Management

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, facility policy, observation, and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered in accordance with professional standards of care for one out of the 19 residents sampled (Resident 1). Findings include: A review of the facility policy titled Oxygen Therapy, last reviewed by the facility on January 23, 2025, revealed it is the facility policy and procedure to ensure the physician's order for oxygen therapy shall include all of the following: (1) oxygen administration modality, (2) liter flow, (3) as needed or continuous administration, and (4) as needed orders must include specific guidelines as to when the resident is to use oxygen. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 7, 2025, revealed that Resident 1 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A clinical record review revealed a physician's order that indicated oxygen as needed due to decreased blood oxygen saturation less than SpO2 88%, with direction to provide oxygen as needed, initiated on February 4, 2025. The physician's order did not include the amount of oxygen per liter required to address Resident 1's low blood oxygen saturation. An observation on March 25, 2025, at 10:20 AM, revealed Resident 1 was in her room receiving oxygen via nasal cannula (medical device used to deliver oxygen a thin flexible tube with two prongs that fit into the nostrils) at 2.0 liters per minute (lpm). During an interview at the same time as the observation on March 25, 2025, Resident 1 did not know her prescribed oxygen liter flow rate. An observation on March 26, 2025, at 11:15 AM, revealed Resident 1 was in her room receiving oxygen via nose cannula at 2.0 liters per minute (lpm). During an interview at the time of the observation, the Director of Nursing (DON) confirmed Resident 1 was receiving 2.0 liters per minute of oxygen via nasal cannula. The DON confirmed Resident 1's physician's order did not indicate a flow rate for oxygen administration. Following inquiries made during the week of the survey, Resident 1 had a revised physician's order to receive oxygen at 2.0 liters per minute via nasal cannula due to a decrease in SpO2 to less than 88% as needed, initiated on March 26, 2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on March 26, 2025, at approximately 11:30 AM, the Director of Nursing confirmed it is the responsibility of the facility to ensure oxygen therapy is administered in accordance with professional standards of care, which includes ensuring physicians' orders indicate the prescribed oxygen flow rate (i.e., how many liters of oxygen per minute). 28 Pa. Code 211.2 (d)(3) Medical director. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review clinical records and staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary use of psychoactive drugs by failing to ensure the presence of clinical rationale for the continued use of an as needed (PRN) psychotropic medication for two of 19 residents reviewed (Residents 75 and Resident 77). Findings include: A review of Resident 75'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, resulting from organic disease of the brain). A review of Resident 75's clinical record revealed a physician's order dated January 7, 2025, directed Lorazepam (anti-anxiety medication) 0.5 mg by mouth every eight hours as needed (PRN) for anxiety, for 167 days. A review of the physician's notes for the months of January and February 2025 revealed the physician failed to document the clinical rationale for the continuation of the PRN order beyond the 14-day limit, nor any re-evaluation of the need for the medication. Review of the March 2025 Medication Administration Record (MAR) showed the Lorazepam was administered 25 times. A review of Resident 77's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Cerebral Infarction (occurs when blood flow to the brain is obstructed, typically by a blood clot, resulting in the death of brain cells) and hemiplegia (one sided paralysis) A review of Resident 77's clinical record revealed a physician's order for Ativan 0.5mg tablet (anti-anxiety medication) 0.5mg by mouth every eight hours as needed (PRN) for anxiety with a start date of February 17, 2025 and discontinued March 13,2025. A new order was written March 13, 2025, for Ativan 0.5 mg every eight hours as needed for anxiety, for 90 days. Review of physician notes from February and March 2025 showed no documentation of a clinical rationale or re-evaluation for continuation of the PRN medication beyond 14 days. A review of the resident's March 2025 Medication Administration Record revealed Ativan 0.5mg was administered to the resident 21 times. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview conducted on March 27, 2025, at approximately 12:30 PM, the Director of Nursing confirmed that no physician documentation was present to justify the continuation of PRN psychotropic medications beyond the 14-day period, and no periodic re-evaluations were documented 28 Pa. Code 211.2 (d)(3)(7)(9) Medical director. 28 Pa. Code 211.12 (d)(3) Nursing services.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 48276 Based on a review of scheduled facility mealtimes, resident committee meeting minutes, grievances filed with the facility, select facility policy, and resident and staff interviews, it was determined the facility failed to consistently provide snacks as desired by residents, including experiences reported by seven out of nine residents during a group interview (Residents 1, 6, 9, 20, 25, 33, and 83). Findings include: A review of facility policy titled Snacks, last reviewed by the facility on January 23, 2025, revealed it is the facility policy that snacks and beverages will be provided as identified in residents' individual plans of care. Bedtime (HS- hour of sleep) snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. Nursing services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. A review of the facility's scheduled mealtimes revealed the time between dinner and breakfast the next day exceeds 14 hours. A review of grievances filed with the facility revealed a grievance dated December 5, 2024, indicating residents at resident council raised concerns that nighttime snacks are not always provided or offered. The resolution section of the grievance indicated in-service training was provided to facility staff. A review of food committee meeting minutes dated March 4, 2025, revealed residents in attendance raised concerns that not all residents were receiving nightly snacks. During a resident group interview on March 26, 2025, at 10:00 AM, seven residents in attendance stated they are not consistently offered a nourishing evening snack (Residents 1, 6, 9, 20, 25, 33, and 83). The residents in attendance indicated that sometimes the facility does not have snacks when the residents request them and explained that staff do not always distribute the snacks to residents. The residents in attendance indicated they have brought this concern to staff's attention, but nothing has improved over the last few months. The residents in attendance expressed frustration about not having evening snacks. During an interview on March 27, 2025, at approximately 1:30 PM, the Nursing Home Administrator (NHA) was unable to explain why residents are reporting the facility is not offering nutritious snacks as desired. The NHA confirmed it is the facility's policy to offer and serve residents a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.