

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395636	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Manor at St Luke Village,the		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on a review of the facility's planned menu, weekly menu cycle, and menu extensions, as well as resident and staff interviews, it was determined that the facility failed to ensure planned menus were sufficiently reviewed and updated to provide adequate variety and to prevent repetitive meal selections in accordance with resident preferences which affected 5 out of 8 residents interviewed, who reported experiencing repetitive meals and limited variation in menu selections that did not reflect their stated food preferences. Findings included: During a Resident Council meeting conducted on January 6, 2026, at 10:00 AM, concerns were raised regarding the lack of variety in the facility's menu. Residents, 34 and 70, indicated that they have a problem with the variety of options on the menu. Residents 34 and 70 explained that the facility continuously serves chicken and pork. Resident 34 indicated that residents have made suggestions during resident group meetings regarding food that they enjoy and would like to see more often, but there has been no action by the facility to address resident concerns. During an interview on January 5, 2026, at 10:40 AM, Resident 53 stated he was frustrated with the menu because the facility continuously serves chicken and pork. He indicated that it is always chicken and pork, and he is sick of the menu. During an interview on January 5, 2026, at 11:30 AM, Resident 5 reported the menu frequently contained repetitive food items, particularly chicken, and lacked variety. She stated the menu choices are not representative of the local area and foods she was accustomed to. She expressed dissatisfaction with pinto beans served as the main entree and stated, Corporate must be from down South. Resident 5 reported that she voiced these concerns during prior Food Committee meetings but felt her concerns were not addressed. During an interview on January 6, 2026, at 9:30 AM, Resident 88 stated she has a problem with the food because the dietary department serves so much chicken. She indicated that she wished the facility had more options for residents. A review of the Fall/Winter 2025-2026 menu, signed by the Registered Dietitian on December 4, 2025, revealed multiple instances of repetitive meal entree patterns throughout the 4-week menu cycle: A review of week 1, revealed Sunday the planned entree for lunch was chicken alfredo and then for lunch on Monday, the planned lunch was chicken tenders, with chicken served for consecutive meals. Monday week 1 dinner, the planned entree was beef and bean chili, and the planned entree for lunch on Tuesday was lasagna with meat sauce, and the planned entree on Wednesday dinner was Salisbury steak (beef), with beef served for consecutive meals. The planned entree for Friday week 1 dinner was BBQ pork platter, and the planned entree for Saturday lunch was BBQ pork on a bun, with pork served for consecutive meals. Sunday week 2, the planned entree for lunch was meat sauce with noodles, and the planned entree for dinner on Monday was sloppy joe on a bun (beef), and the planned entree for Tuesday lunch was cheeseburger on a bun, and the planned entree for Wednesday dinner was meatloaf, and the planned entree for Thursday was beef soft tacos, with beef served for consecutive meals. Sunday week 2, the planned entree for dinner was rotisserie chicken, and the planned entree for lunch on Monday was BBQ chicken thigh, and the planned entree for dinner on Tuesday was maple Dijon chicken breast, and the planned entree for lunch on Wednesday was fried chicken, and the planned entree for dinner on Thursday was marinated chicken breast, with chicken served for consecutive meals. These repetitive meal patterns (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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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	demonstrated that the facility failed to provide sufficient variety within the planned menu cycle, contributing to resident dissatisfaction and menu fatigue. During an interview on January 7, 2026, at 11:50 AM, the Dietary District Manager stated the regional corporate office was responsible for providing the facility with a 4-week seasonal menu, which was reviewed by the facility's Registered Dietitian. She further stated that the facility offered a resident choice meal one time per month, determined by attendees at Food Committee meetings. During an interview on January 8, 2026, at 10:00AM, the Nursing Home Administrator confirmed that similar foods were served for consecutive meals. The facility failed to ensure the planned menus were adequately reviewed and modified to provide sufficient variety and reflect resident preferences, resulting in repetitive meal patterns that did not meet the satisfaction of the residents. Refer F56528 Pa. Code 201.29(a) Resident rights.28 Pa. Code 211.6 (a) Dietary services.		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a review of facility policy, Resident Council meetings minutes, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to promptly resolve continued resident complaints and grievances expressed during resident group meetings, including those voiced by five of five residents attending a resident group meeting (Residents 8, 11, 16, 34, and 70), and failed to keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution. Findings include: A review of the facility's Resident and Family Grievances policy, last reviewed on July 24, 2025, revealed grievances may be voiced as a verbal complaint to a staff member, a written complaint to a staff member, or a verbal complaint during resident or family council meetings. The policy indicated the staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident to complete the form. The facility will take steps to resolve the grievance and record information about the grievance and those actions on the grievance form. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow-up. The policy indicated the facility will take prompt efforts to resolve the grievance (including acknowledgment of a complaint or grievance and actively working toward resolution of that complaint or grievance). A review of food committee meeting minutes dated October 7, 2025, revealed residents in attendance requested the menu to include more soups with meat, pierogies, and more cooking demonstration activities (an activity with dietary services to review menu options and an opportunity for resident feedback). Residents in attendance raised concerns about being able to choose snacks and snacks not arriving with labels. A review of food committee meeting minutes dated November 4, 2025, revealed residents in attendance would like the menu to include more pierogies, Polish foods, soups, and meal options at dinner and to have more cooking demonstrations. A review of food committee meeting minutes dated December 2, 2025, revealed residents in attendance indicated complaints that fish and pork are not generally liked, snacks are refused often because the snacks are labeled with resident information, and there are no snack options. Residents also identified food items they would like to include: fish, stewed tomatoes, and crab cakes. During a resident group interview on January 6, 2026, at 10:00 AM, with alert and oriented residents that normally attend resident council meetings, five of five residents (Residents 8, 11, 16, 34, and 70) indicated when they bring up food concerns at meetings, the facility does not respond to their concerns. Residents 8, 11, 16, 34, and 70 indicated they continue to have concerns about dietary services such as the menu, food temperature, meal variety, and snacks. Residents 8, 11, 16, 34, and 70 indicated that the facility does not respond to the group's concerns about these issues, and their concerns have not been resolved. During the interview, Resident 16 indicated that she had concerns that she does not always receive a snack. During the interview, Resident 34 indicated that she was upset because she was given a snack each night without having the option to make a choice. She explained the snacks arrive with her name on them, and she cannot make a choice about what snack she would like. Resident 34 also indicated that the menu variety was limited and they are served too much pork and chicken. She also indicated the food was not hot. Resident 34 explained that she has brought these issues up during each meeting, but there have been no attempts to resolve these concerns for several months. During the interview, Resident 70 indicated that sometimes she was not offered a snack, and the fresh fruit she was served was hot because of the manner it was stored on the serving trays. She also indicated that the facility serves the same foods, and she would like more variety. Resident 70 explained that residents have made recommendations for foods they enjoy, but the facility does not respond to their concerns about food. During the interview, Resident 8 indicated that she had raised concerns about snacks at previous meetings, but nothing has been done to address her issues. She indicated she reported enjoying ice cream as a snack but was only provided a sandwich that she does not eat. Resident 8 also indicated that her eggs are served cold and the coffee was not hot. She confirmed (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	these issues have not been resolved, despite raising the issues during group meetings. During the meeting, Resident 11 indicated that he was offered a snack every day but does not have a choice in what was served. Resident 11 explained that the same item was delivered each day, and he does not have an option. He also indicated that his fresh fruit was served hot because it was transported on the hot portion of his tray. Resident 11 confirmed that residents have brought these issues up at meetings, but the issues have not been resolved. During an interview on January 7, 2026, at 12:55 PM, the Registered Dietician confirmed she meets with the resident groups to discuss food and dietary services each month. The Registered Dietician was unable to provide documented evidence that the facility was resolving and addressing complaints and grievances residents raise during group meetings. During an interview on January 8, 2025, at 10:45 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA was unable to provide documented evidence that the facility was addressing, responding to, or resolving resident complaints and grievances related to food and dietary services raised during resident group meetings. The facility failed to put forth sufficient efforts to promptly resolve continued resident complaints and grievances expressed during resident group meetings, including those voiced by Residents 8, 11, 16, 34, and 70. Refer F80328 Pa. Code 201.18 (e)(1) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.12 (d)(3) Nursing services.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, review of manufacturer recommendations, and staff interviews, it was determined that the facility failed to ensure a safe and orderly environment related to the placement of a personal appliance for one of 12 residents sampled who had personal refrigerators (Resident 23). Findings include: An observation conducted in Resident 23's room on January 5, 2026, at approximately 10:00 AM, revealed the resident had a personal refrigerator located on top of a bedside cabinet. The bedside cabinet did not adequately accommodate the full base of the refrigerator. Observations revealed that a portion of the refrigerator base extended beyond the edge of the cabinet, resulting in an unbalanced surface (one in which the weight of an object is not evenly distributed across its supporting base, creating a risk for tipping or falling). The refrigerator was three feet off the ground, further increasing the potential for injury should the appliance fall. A review of the refrigerator manufacturer's instruction manual indicated that the appliance was required to be placed firmly on a flat, stable surface that fully supports the size and weight of the unit to prevent tipping, shifting, or falling. During an interview conducted on January 5, 2026, at 1:30 PM the Nursing Home Administrator acknowledged the refrigerator was not appropriately sized to be placed on the bedside cabinet. 28 Pa. Code 201.18(b)(1)(3)(e)(2.1) Management		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of select facility policy, clinical record review, and staff and resident interviews it was determined the facility failed to timely evaluate nutritional requirements to ensure acceptable parameters of nutritional status for two of 26 sampled residents were being maintained (Residents 5 and 29). Findings include: A review of the facility's policy entitled Weight Monitoring, reviewed July 24, 2025, identified that weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or unhealthy weight loss over a period of time may indicate a nutritional problem. The facility will utilize a systematic approach to identify residents at risk, evaluate and analyze the assessment information, implement pertinent approaches, and monitor the effectiveness of these approaches. Further it was indicted a weight monitoring schedule will be developed upon admission for all residents. Newly admitted residents will have weights monitored weekly for four weeks and then monthly thereafter. Residents with identified weight loss will be monitored weekly. Significant weight changes would include a 5% change in weight in one month, a 7.5% change in 3 months, or a 10% change in 6 months. Meal completion information should be recorded and may be referenced by the interdisciplinary team as needed. A review of Resident 5's clinical record revealed admission to the facility on January 26, 2017, with diagnoses which included muscle wasting. A quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 29, 2025, revealed the resident's 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 to 15 indicates cognition is intact) and was wheelchair bound. During an interview conducted with Resident 5 on January 5, 2026, at 11:30 AM, the resident reported transfers were completed using a mechanical lift (a powered medical device used to lift and transfer residents safely). The resident reported being weighed either by mechanical lift or while seated in a wheelchair and denied participating in activities that would reasonably account for large fluctuations in body weight gain/loss. A review of Resident 5's weight records from July 4, 2025, through January 7, 2026, revealed multiple significant weight changes, including both a substantial loss and gain: July 4, 2025- 268.5 lbs. August 1, 2025- 268 lbs. August 3, 2025- 268 lbs. September 1, 2025- 280.5 lbs. November 1, 2025- 234.5 lbs. November 11, 2025- 234.5 lbs. December 1, 2025- 234.5 lbs. January 3, 2026- 299.8 lbs. January 7, 2026- 298 lbs. The record lacked documented evidence that reweighs were obtained to verify the accuracy of these extreme variations. An interdisciplinary note dated November 5, 2025, at 8:31 AM, indicated the resident experienced a 7.5 percent weight loss since August 3, 2025 (weight variation from 268 lbs. to 234.5 lbs.), however, review of documented weights revealed a greater degree of fluctuation. Specifically, the change from September 1, 2025 (280.5 lbs.) to November 1, 2025 (234.5 lbs.) represented a 16.4 percent weight loss, and the change from December 1, 2025 (234.5 lbs.) to January 3, 2026 (299.8 lbs.) represented a 27.85 percent weight gain. The clinical record lacked evidence that these extreme fluctuations were questioned, validated, or investigated to determine whether contributing factors such as medical conditions, equipment consistency, weighing method, or staff practices were influencing weight accuracy. There was also no evidence that nutritional parameters were reassessed to ensure the resident's nutritional status remained acceptable. During an interview conducted with the dietician on January 6, 2026, at 1:30 PM, it was confirmed that Resident 5 experienced weight fluctuations exceeding the facility's defined thresholds for significant weight change. of 5% in 30 days, 7.5% in 3 months, and 10% in six months. A review of Resident 29's clinical record revealed admission to the facility on December 17, 2025, with a diagnosis that included muscle weakness (a condition that may affect mobility, endurance, and nutritional needs). An admission MDS dated [DATE], indicated the resident had a BIMS score of 14, reflecting intact cognition. During an interview conducted with Resident 29 on January 5, 2026, at (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:00 AM, the resident reported not eating due to dissatisfaction with meals offered, specifically meals containing beef, which the resident reported were not recommended by his physician. The resident further reported experiencing weight loss.A review of Resident 29's weight record revealed that on admission the resident was 137 lbs. December 20, 2025: 131.5 lbs.December 23, 2025: 134.5 lbs. A scheduled weigh-in on December 30, 2025, was refused by the resident. The next documented weight was obtained on January 6, 2026, which indicated the resident weighed 123.5 lbs., representing a 9.85 percent weight loss from admission. The clinical record lacked evidence that additional attempts were made to obtain a timely reweight following the refusal on December 30, 2025, to identify potential ongoing weight loss and implement interventions prior to the documented January 6, 2026, weight. An observation of Resident 29's lunch meal on January 5, 2026, at 11:42 AM and again at 12:15 PM, revealed the resident consumed 0 percent of the meal. Review of meal completion documentation for the same period reflected intake inaccurately documented between 26 percent and 50 percent. During an interview conducted with the dietician on January 8, 2026, at 1:30 PM, it was confirmed that meals containing beef were served on December 18, 25, 26, and 30, 2025, and January 5, 6, and 7, 2026. The dietician indicated that Resident 29 was offered alternative meals that did not consist of beef; however, they were unable to provide evidence of what those meals were and if acceptable meal completion was noted for those alternatives to evaluate if the weight loss was in conjunction with either poor meal completion, resident preference, staff accuracy documenting meal completion, or a combination of all the above. The dietician also confirmed that no additional weights were attempted following the December 30, 2025, refusal prior to the documented 13.5-pound weight loss identified on January 6, 2026. The facility failed to provide evidence that significant weight changes were accurately verified, timely identified, thoroughly assessed, and appropriately acted upon for Residents 5 and 29. The facility further failed to ensure consistent weighing practices, accurate meal intake documentation, and timely nutritional interventions to maintain acceptable parameters of nutritional status. 28 Pa Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, select policy review, and staff interview, it was determined the facility failed to ensure that food storage in personal refrigerators were adequately monitored and maintained within safe temperatures to prevent foodborne illness for one of 12 residents with personal refrigerators (Resident 23). Findings include: Review of the facility policy entitled Safe Food Handling for Foods from Visitors last reviewed July 24, 2025, revealed that residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors. Staff will request that visitors notify someone from the activities or nursing department when a food item is brought in for immediate consumption or for something to be consumed at a later date. Food intended for later consumption will have labels placed on the item by staff, which will indicate the resident's name and current date. Foods noted to be 7 days or older from when placed into the refrigerator are to be discarded. Further it was indicated refrigerators storing food will be maintained and monitored on a daily basis to ensure the temperature inside the refrigerator is 41 degrees Fahrenheit or less. An observation of Resident 23's room on January 5, 2026, at approximately 10:00 AM revealed the resident had a personal refrigerator in the room. Upon opening the refrigerator, it was noted the temperature inside the refrigerator was approximately 48 degrees Fahrenheit. It was also noted that there was an unlabeled container of food that was not dated as to when or how long the item was stored in the refrigerator. An observation of Resident 23's refrigerator on January 5, 2026, at 1:30 PM with the nursing home administrator revealed and confirmed that the temperature inside the refrigerator was 48 degrees Fahrenheit and that the food in the container was not labeled with a date or the resident's name. The nursing home administrator indicated that staff are to monitor the temperature inside the refrigerator daily, and this should be recorded. A review of Resident 23's refrigerator temperature logs for January 2026 revealed staff were only to take action for refrigerator temperatures exceeding 46 degrees Fahrenheit, which was not in conjunction with facility policy for safe food storage. In addition, on January 1, 2026, and January 4, 2026, there was no evidence that monitoring Resident 23's refrigerator was completed. On January 2, 3, and 5, 2026, the temperature inside the refrigerator was noted to be 42 degrees Fahrenheit, which was above the appropriate temperature as outlined in facility policy. The interview with the nursing home administrator on January 6, 2026, at 9:00 AM, was unable to provide additional information that would explain why staff monitoring inside refrigerator temperatures were not aware of the facility policy for safe food storage, why the temperature logs directed staff to only intercede with refrigerator temperature regulation after temperatures exceeded 46 degrees Fahrenheit, and why this resident's food was not appropriately labeled and date. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa. Code 211.10(d) Resident care policies.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy, review of resident financial records, and resident and staff interviews, the facility failed to safeguard, manage, or accurately account for the resident's personal funds deposited with the facility for one out of 26 residents sampled (Resident 53). Findings include: A review of the facility policy titled Resident Person Funds, last reviewed by the facility on July 24, 2025, revealed if the resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary (an organization that is legally and ethically required to act in the best interest of another person) of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. A review of the facility form titled Resident Trust Fund Notification and Authorization, last reviewed by the facility on July 24, 2025, revealed procedures for residents' withdrawals and purchases. The form indicated that requests for less than \$50 for those residents whose care is funded by Medicaid will be honored within the same day. A clinical record review revealed Resident 53 was admitted to the facility on [DATE], with diagnoses that included pulmonary embolism (a blood clot that prevents blood flow to the lungs and potentially causes life-threatening symptoms like sudden shortness of breath, chest pain, and fainting) and rhabdomyolysis (a serious condition where damaged muscle tissue breaks down rapidly, releasing harmful substances into the bloodstream). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 15, 2025, revealed that Resident 53 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 to 15 indicates cognition is intact). During an interview on January 5, 2026, at 10:40 AM, Resident 53 indicated that he was angry and frustrated because yesterday (Sunday), January 4, 2026, he attempted to retrieve his money from Employee 2, Receptionist, but she reported that she was not able to give him his money because she did not have his account information. Resident 53 expressed that he was angry because he wanted to buy a hoagie. Resident 53 confirmed that later in the evening, Employee 3, Nurse Aide (NA), gave him \$10.00 of her own money until the issue was resolved. During an interview on January 7, 2026, at 11:32 AM, Employee 2 confirmed that she did not give Resident 53 his funds on Sunday, January 4, 2026, because she did not have access to his account information. Employee 2 indicated that the resident became upset and yelled. Employee 2 explained that her access to resident account information was not working since August 2025. She indicated that she must speak to the Business Office Manager (BOM) to ensure that residents have enough money before allowing residents to make withdrawals from the petty cash. Employee 2 indicated that on Sunday, January 4, 2026, the BOM was not working, and she did not contact the BOM for Resident 53's personal fund information on January 4, 2025. During an interview on January 7, 2026, at 11:40 AM, the Business Office Manager indicated on January 4, 2026, Resident 53 had \$47.17 available. The BOM confirmed that the Receptionist must contact her to know how much residents have in their accounts. The BOM confirmed that she was not contacted on January 4, 2025. The BOM provided a receipt indicating that Employee 3, Nurse Aide, was reimbursed for \$10.00. During an interview on January 8, 2025, at 10:45 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The facility failed to ensure residents have access to their personal funds for withdrawals less than \$50.00 and ensure a process is in place to accurately account for residents' personal funds. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a) Resident rights.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to develop and implement a discharge plan that accurately reflected a resident's discharge goal or preferences for two out of 26 residents reviewed (Residents 3 and 40). Findings included: A review of the facility policy entitled Discharge of Resident to Home or Other Center, last reviewed by the facility on July 24, 2025, revealed it was the policy of the facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals and the preparation of the residents to be active participants in the discharge planning process. The policy indicated the facility will determine the resident's expected goals and outcomes regarding discharge upon admission, during care plan meeting reviews, and as needed. The policy further indicated if discharge to the community was determined to be unsafe and unrealistic goals are identified, the facility will document in the clinical record who made the determination and why. The policy revealed the evaluation of the resident's discharge needs and discharge plan will be completely documented in a timely manner in the resident's clinical record. A clinical record review revealed Resident 40 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated October 20, 2025, revealed Resident 40 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 to 15 indicates cognition is intact). A review of the quarterly MDS dated [DATE], Section D0150 Resident Mood Interview (Patient Health Questionnaire series, a set of self-report questionnaires for screening and monitoring depression) revealed Resident 40 indicated he had been feeling down, depressed, or hopeless two to six days over the past two weeks. Further review of the quarterly MDS dated [DATE], Section Q0400 Discharge Plan, revealed active discharge planning for Resident 40 to return to the community was not occurring. A review of the resident's current plan of care initiated on February 8, 2022, indicated Resident 40 wished to remain a long-term care resident. Interventions included evaluating the resident's motivation to return to the community. Further review of Resident 40's care plan dated February 18, 2022, revealed the resident had a decline in activities of daily living (ADLs, fundamental self-care tasks like bathing, dressing, eating, toileting, transferring or moving, and continence, used to measure a person's functional independence). Interventions indicated the resident was independent with bed mobility, dressing, eating, transferring, toilet use, and personal hygiene. Further it was noted the resident was independent-supervision with one staff member for showering or bathing. A progress note dated June 7, 2025, at 9:29 AM revealed Resident 40 was in long-term care, as his wife cannot manage his care at home. A progress note dated July 16, 2025, at 8:00 PM revealed Resident 40 would like to go home and be with his wife. The resident noted his feelings of depression and anxiety were related to being in a nursing home. A progress note dated October 1, 2025, at 8:00 PM revealed Resident 40 wanted to go home and be with his wife. The resident rated his depression and anxiety as four out of ten, with ten being the worst. The note indicated that his mood was terrible related to wanting to go home. A progress note dated December 10, 2025, at 5:00 PM revealed Resident 40 stated his wife was home alone and he would like to go home and help her. The resident rated his depression and anxiety as six out of ten, with ten being the worst. The resident's mood was indicated as miserable related to him wanting to go home. Further it was indicated solution-focused therapy was utilized to help Resident 40 brainstorm possible solutions (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for these issues. During an interview on January 5, 2026, at 10:55 AM, Resident 40 explained that he does not want to remain in the facility. He indicated that his preference and goals are to be discharged home. Resident 40 explained that he was ambulatory, independent, and takes care of himself. He indicated that the facility staff have told him he was not safe to be discharged . During an interview on January 6, 2026, at 12:22 PM, Employee 1, Social Services Assistant, confirmed Resident 40 had indicated he would like to go home in the past. She confirmed that discharge planning has not been initiated. Employee 1 confirmed that the resident's care plan does not match his wishes and preferences to return to the community. During an interview on January 8, 2026, at 10:45 AM, the Nursing Home Administrator (NHA) confirmed the facility was not actively working on Resident 40's discharge and that Resident 40's care plan did not accurately include his preferences and wishes to return to the community. The NHA was not able to provide documented evidence indicating the clinical rationale preventing Resident 40 from returning to the community. The facility failed to develop and implement a discharge plan that accurately reflected Resident 40's discharge goals, preferences, and/or included barriers preventing the resident's discharge to the community. A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include encephalopathy (broad term for any disorder or disease affecting the brain's function, causing confusion, memory loss, personality changes or altered consciousness), bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and schizophrenia (a severe, chronic brain disorder that disrupts how a person thinks, feels, and behaves, causing them to interpret reality abnormally through symptoms like hallucinations and delusions). A review of an admission MDS assessment dated [DATE], revealed that Resident 3 was cognitively intact with a BIMS score of 14. Further review of the resident's admission MDS assessment revealed Section Q (a section used for resident goal setting) indicated the resident's overall discharge plan was to discharge to another facility and/or institution. A review of a Social Services progress note dated May 13, 2025, at 4:18 PM, indicated the care plan meeting was held with the Interdisciplinary Team and Resident 3's brother. During the meeting, Resident 3's brother indicated the discharge plan was for long-term care. A review of Resident 3's comprehensive care plan, initiated on April 12, 2025, revealed the current care plan did not identify or address a discharge plan, including transfer to another facility or remaining in the facility for long-term placement, despite documented discharge discussions and decisions. During an interview with the Director of Nursing (DON) on January 7, 2026, at 11:35 AM, the DON confirmed that discharge planning information was absent from Resident 3's care plan prior to the survey. 28 Pa. Code 201.29(a) Resident rights.28 Pa. Code 201.18(e)(1) Management.28 Pa Code 211.10 (a)(c) Resident care policies.28 Pa. Code 211.12 (d)(3) Nursing services.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff and resident interviews, it was determined the facility failed to ensure that residents received proper treatment and assistive devices to maintain vision and arrange for treatment by a professional specializing in the provision of vision assistive devices as needed for one out of 26 residents sampled (Resident 6). Findings include: A review of the facility policy titled Hearing and Vision Services, last reviewed by the facility on July 24, 2025, revealed it is the policy of the facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as needed. Further review revealed that staff should refer any identified need for hearing or vision services/appliances to the social worker/social service designee. Once vision or hearing services have been identified, the social worker/social service designee will assist the resident by making appointments and arranging for transportation. A clinical record review revealed Resident 6 was admitted to the facility on [DATE], with diagnoses that included diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of sugar in the blood and urine) and end stage renal disease and was dependent on dialysis (the process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). A review of a Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 29, 2025, revealed that Resident 6 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). A clinical record review revealed that Resident 6's last evaluation for visual acuity (a test to determine how clearly a person can see, the ability to see details and objects at near or far distances, with or without glasses) was on July 3, 2025, with follow up noted in six to nine months. A review of a nursing progress note dated November 17, 2025, at 11:59 AM, revealed there was a new optician (person qualified to make and supply eyeglasses for correction of vision) consult related to a decrease in vision since the resident's last dialysis visit. A review of a physician's order dated November 17, 2025, at 12:00 PM, revealed an order for an optician consultation due to a decrease in vision since the last dialysis visit. A clinical record review at the time of the survey on January 7, 2026, revealed no evidence that the resident was seen by an optician. During an interview with the Nursing Home Administrator (NHA) on January 7, 2026, at 1:00 PM, it was revealed that the resident was due to be seen by the optician on his next follow up appointment on February 25, 2026, and it was confirmed that an appointment was not made for him other than his follow up appointment, despite a physician's order for one. During an interview with Resident 6 on January 8, 2026, at 12:00 PM, the resident revealed he had been experiencing decreased vision for several months and felt like his glasses needed some adjustment. The facility failed to ensure Resident 6 received proper treatment and assistive devices to maintain vision and arranged for treatment by a professional specializing in the provision of vision assistive devices. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy review, investigative documentation provided by the facility, and staff interviews it was determined the facility displayed past non-compliance by failing to ensure the safety and supervision of one resident identified at risk for wandering and elopement from exiting through unsecured doors for one out of 26 residents sampled (Resident 89). Findings include: A review of the facility policy titled Elopement/Wandering Risk Guideline, last reviewed by the facility on July 24, 2025, revealed it is the policy of the facility to evaluate and identify residents that are at risk of elopement and develop individualized interventions. A review of the facility policy titled Missing Patient/Resident, last reviewed by the facility on July 24, 2025, revealed it is the policy of the facility that staff will investigate cases of missing residents and possible elopement. Further review revealed that elopement occurs when a resident leaves the premises or a safe area without authorization and/or necessary supervision to do so, placing the resident at risk for harm or injury. A review of the clinical record revealed that Resident 89 was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and major depressive disorder (a mental health disorder characterized by a persistently low or depressed mood, decreased interest in pleasurable activities, feelings of worthlessness, lack of energy, poor concentration, appetite changes, sleep disturbances, or suicidal thoughts). A review of the resident's quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated July 9, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 07 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 to 7 indicates severe cognitive impairment). A review of the resident's care plan initiated June 14, 2023, revealed Resident 89 was identified as being at risk for elopement related to impaired safety awareness, with an established goal that the resident would not leave the facility unattended. A review of an elopement risk assessment dated [DATE], identified the resident as being at low risk for elopement. A review of a nursing progress note documented by Employee 4 (Registered Nurse, RN) dated August 16, 2025, at 12:51 AM, revealed that Resident 89 exited the facility without being observed by staff and was located in the facility parking lot. The resident was returned to the facility without incident. A body check was completed, and the resident was noted to be in stable condition. The physician and resident representative were notified, and a wander guard bracelet, defined as an electronic monitoring device used to alert staff when a resident approaches or exits a secure area, was applied to the resident's left wrist. A review of a written witness statement dated August 15, 2025, from Employee 5 (Nurse Aide) revealed that during routine rounds at approximately 10:00 PM, the employee assisted the resident in bed one and then proceeded to bed two, identified as Resident 89. The employee observed Resident 89 up in his wheelchair. The employee asked if the resident required incontinence care, which the resident declined, stating he was okay. The employee then exited the room. The employee reported she did not observe the resident in the corridor at that time and did not note the resident to be upset or distressed. A review of a written witness statement dated August 15, 2025, from Employee 7 (Licensed Practical Nurse) revealed resident care was provided throughout the shift, and at no time did Resident 89 verbalize an intent to leave the facility. The employee stated the resident was present in his room prior to the incident. The employee further reported taking a 15-minute break at approximately 10:00 PM in the back parking lot and did not observe any individuals in the parking lot at that time. A review of a written witness statement dated August 15, 2025, from Employee 8 (Licensed Practical Nurse) revealed the employee was working on the upper east unit with another resident and observed Resident 89 pass by in his wheelchair. The employee indicated no (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate concern was raised because the resident was known to occasionally go to the front area of the building during the evening hours. A review of a written witness statement dated August 15, 2025, from Employee 4 (Registered Nurse) revealed the resident was later identified to have exited the facility. The employee stated the resident had previously been observed in his bed during routine rounds conducted by nursing staff. The resident was subsequently returned to the facility without incident. A body check was completed, and the resident was noted to have no apparent injuries or ill effects. The resident was described as alert and aware and stated he had gone outside to get fresh air. Vital signs were obtained, and the physician and resident representative were notified. A wander guard was applied to the resident. A review of a written witness statement dated August 16, 2025, from Employee 6 (Licensed Practical Nurse) revealed that at approximately 10:10 PM on the evening of August 15, 2025, the employee was completing end-of-shift documentation when alerted by a notification from the phone camera at the front door. The employee observed an individual looking into the camera and heard the individual request assistance, stating there was a man in a wheelchair outside who had provided his name. The employee recognized the name as a resident and, upon approaching the front door, observed Resident 89 seated in his wheelchair outside the building. A review of a written witness statement dated August 16, 2025, from Employee 9 (Receptionist) revealed the employee stated the front door had been locked at approximately 8:00 PM prior to leaving for the day. The employee further indicated they checked the exterior of the door before leaving for the day. A review of a physician order dated August 16, 2025, revealed an order was obtained for application of a wander guard bracelet and for staff to check placement each shift. A review of an elopement risk assessment dated [DATE], revealed Resident 89 was reassessed and identified as being at high risk for elopement. During a telephone interview conducted January 7, 2026, at 2:20 PM, Employee 5, a Nurse Aide, confirmed she had completed routine rounds, assisted the resident shortly before the incident, and learned approximately ten minutes later that the resident had been found outside the building. During an interview conducted January 7, 2026, at 1:00 PM, the Nursing Home Administrator confirmed the facility did not have a proper locking process in place at the time of the elopement and that a new locking system was implemented following the incident on August 15, 2025. These findings demonstrated the facility failed to ensure effective supervision and implement adequate environmental and monitoring safeguards for a resident with impaired cognition and impaired safety awareness, resulting in an unsupervised exit from the facility. This deficiency is cited as past noncompliance. The facility's corrective action plan was to identify other residents with the potential to be affected, and a headcount was completed, all door locks were checked, and residents with wander guards were checked for placement and function on August 15, 2025. Education was provided, starting on August 15, 2025, regarding alarming the front door for RN supervisors immediately. On August 16, 2025, another facility-wide check of all doors and door locks was completed, windows were checked to ensure proper opening compliance and good repair, and the Wander Guard system was checked to ensure proper function. Elopement assessments were initiated and completed on all residents. Any newly identified residents with high scores for risk of elopement had their plans of care reviewed to ensure accuracy and appropriate interventions. To prevent this from recurring, the NHA and Interdisciplinary Team (IDT) provided re-education to facility staff regarding the facility's elopement policy, including procedures and protocols, initiated on August 16, 2025, with completion on August 19, 2025. Registered Nurses were educated on the alarm setting protocol that was in place immediately, in which protocols were in place and were locking the doors as of August 16, 2025. A new system for unmanned front door building access for after-hours was implemented on August 19, 2025. This included locking the front doors and unlocking the front doors for the process of after-hours entrance and exit. Additional education was initiated on August 19, 2025, and was completed before starting the shift. To monitor and maintain ongoing compliance, the facility completed two elopement drills on each shift throughout the month of August to ensure elopement protocols are followed. The findings of the plan of correction were submitted to QAPI for review. The (continued on next page)		

Department of Health & Human Services
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's immediate corrective action plan was completed on August 28, 2025. A demonstration of the door locking with the new locking system protocol was conducted on January 7, 2026, at 1:00 PM, by Employee 2 and observed by the surveyor without any concerns.28 Pa Code 201.14(a) Responsibility of Licensee.28 Pa Code 201.18(b)(1) (e)(1) Management.28 Pa Code 211.10 (a)(c) Resident care policies.28 Pa Code 211.12(c)(d)(1)(3)(5) Nursing Services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews with facility staff, it was determined the facility failed to evaluate the clinical necessity of an indwelling urinary catheter for one out of 26 residents sampled (Resident 76). Findings included: A review of the facility policy titled Incontinence, last reviewed by the facility on July 24, 2025, revealed it is the facility policy that residents who enter the facility with an indwelling catheter (a flexible tube used for draining urine from the bladder and having an inflatable part at the bladder end that allows the tube to be kept in place for variable time periods), or receive one while in the facility, will be assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization was necessary. A clinical record review revealed Resident 76 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of a Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 21, 2025, revealed that Resident 76 was cognitively intact with a BIMS score of 14 (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 to 15 indicates cognition is intact). A clinical record review of a physician's order for Resident 76 dated December 24, 2025, revealed an order for a Foley catheter (a small flexible tube inserted into the urethra to drain urine from the bladder) with a diagnosis of obstructive uropathy (a blockage in the urinary tract that stops urine from flowing out). A review of a nurse practitioner's progress note for Resident 76 dated December 26, 2025, revealed the resident had a Foley catheter inserted during hospitalization prior to admission, and the plan was for a voiding trial (a test in which a urinary catheter is removed or clamped to determine whether a resident can urinate on their own and adequately empty the bladder without urinary retention) and to refer to urology (medical specialty that focuses on the diagnosis and treatment of conditions affecting the kidneys and bladder) if the trial failed. A review of a nurse practitioner's progress note for Resident 76 dated December 31, 2025, revealed the resident had a Foley catheter, and it was unclear if a voiding trial was attempted at the facility, and the plan was for a voiding trial with the Foley catheter to be removed and to straight catheterize (one time insertion of a catheter into the bladder to drain urine). If the resident is unable to urinate in eight hours and to retain the Foley for urine residual (amount of urine left in the bladder after urination) greater than 300 milliliters (ml). A clinical record review at the time of the survey on January 6, 2026, revealed no evidence that the resident had a voiding trial and that the Foley catheter was discontinued. During an interview with Resident 76 on January 6, 2026, at 9:00 AM, it was revealed that the Foley catheter was new for her and it was inserted prior to admission to the facility while she was in the hospital, and she stated she wished it could be removed because it was uncomfortable and burned. An interview with the Director of Nursing (DON) on January 6, 2026, at 12:15 PM, revealed that nursing staff are responsible for reading physician or physician extender notes regarding resident clinical information and recommendations. Following surveyor inquiry, a physician's order was noted on January 6, 2026, at 4:42 PM, for Foley catheter removal and voiding trial, and to straight catheterize the resident if unable to void in eight hours from removal and retain the Foley catheter if there is a residual greater than 300 ml. A clinical record review of a nursing progress note dated January 6, 2026, at 6:53 PM, revealed that the resident was incontinent with a moderate amount of urine at that time. During an interview with the DON on January 7, 2026, at 9:35 AM, it was confirmed that the facility failed to timely reassess the need for catheter placement for Resident 76. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services.		