STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395037	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Court Skilled Nursing and Rehabilitation	2400 Kingston Court York, PA 17402

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33305 Based upon clinical record review and staff and resident interviews, it was determined the facility failed to provide transfer out of bed services per preference for one of 23 residents reviewed (Resident 1). Findings include: Review of the clinical record revealed that Resident 1 had diagnoses that included multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves) and atrial fibrillation (an irregular, often rapid heart rate). Resident 1 was admitted to the facility on [DATE], for long term stay at the facility. A review of Resident 1's Quarterly Minimum Data Set (periodic assessment of needs) dated November 8, 2024, revealed the Resident required extensive assist of 2-persons for transfer out of bed. Resident 1's BIM score (brief interview of mental status) was 15, indicating she is cognitively intact. During an interview with Resident 1 on January 7, 2024, at approximately 11:30 AM, she confirmed that she had placed her call bell on to get out of bed in the morning, but no one transferred her out of bed until 4:30 PM. Resident confirmed that she is usually out of bed by lunch time. Resident stated that she is transferred via a lift, and stated sometimes it's not working, then I have to wait for another lift. Resident 13, who is Resident 1's roommate, confirmed that staff did not respond to the Resident's request to get out of bed until 4:30 PM. Resident 13's BIMS score (brief interview of mental status) was 15, indicating she was cognitively intact. Roommate also confirmed that Resident 1 is typically out of bed by noon. During an interview with Employee 1 (Nurse Aide) on January 7, 2024, she stated that Resident 1 was washed and changed in the AM on December 28, 2024, she added that the Resident gets out of bed at different times. The Employee was unable to explain the delay in getting the Resident out of bed. Interview with the Director of Nursing (DON) on January 7, 2025, at 1:00 PM, agreed that residents should be transferred out of bed upon request and timely. The DON also confirmed that there is no non-functional Hoyer lifts or sit to stand-lifts, and the only time one of the lifts is not available is when they are being charged. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(c)(d)(1)(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33305 Based on clinical record review, policy review, and staff interview, it was determined that the facility failed to provide the highest practicable care and follow professional standards of practice for wound care for one of 23 residents reviewed (Resident 9), and failed to follow scheduled medication times based on the documented administration time for 21 of 23 residents reviewed (Residents 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, and 23). Findings include: A review of the facility policy, titled Skin Integrity and Wound Management, last revised October 15, 2024, stated implement wound care treatments, as indicated and ordered. On December 28, 2024, Employee 2 (Registered Nurse) reviewed wound care treatments for the dayshift (7AM to 3PM), due to the dayshift nurse delay in medication pass. Employee 2 provided a written statement to the Director of Nursing (DON) that stated, there were treatments that were signed off completed but the date on the treatment was 12/27/24. I completed the treatment on the evening shift. The wound care that was signed off as completed on dayshift December 28, 2024, but was not completed until evening shift involved Resident 9. Review of Resident 9's clinical record revealed that the Resident had a lateral right ankle vascular ulcer that was ordered to have cleansing, then apply medihoney and alginate (wound dressings) to the wound base, and cover with a foam dressing every dayshift and PRN (as needed). A review of the facility policy, titled medication Administration, last reviewed January 2024, stated, medications are administered within 60 minutes of the scheduled time .the individual who administers the medications records the administration on the residents Medication Administration Record (MAR) immediately for all medications administered. A review of the clinical record for Resident 1 revealed on December 28, 2024, her medications were administered late. Resident 1 was scheduled to receive 13 medications between 7:15 AM and 9:00 AM. Resident received medications 3 to 8 1/2 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 2 revealed on December 28, 2024, medications were administered late. Resident 2 was scheduled to receive 15 medications between 7:15 AM and 9:00 AM. Resident received medications 1 1/2 to 5 1/2 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 4 revealed on December 28, 2024, medications were administered late. Resident 4 was scheduled to receive 14 medications between 7:15 AM and 9:00 AM. Resident received medications 5 1/2 to 9 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 5 revealed on December 28, 2024, medications were administered late. Resident 5 was scheduled to receive 9 medications between 7:00 AM and 10:00 AM. Resident received medications 6 to 8 hours later than scheduled per documentation in the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record for Resident 6 revealed on December 28, 2024, medications were administered late. Resident 6 was scheduled to receive 7 medications between 8:00 AM and 2:00 PM. Resident received medications 1 to 3 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 7 revealed on December 28, 2024, medications were administered late. Resident 7 was scheduled to receive 18 medications between 8:00 AM and 10:00 AM. Resident received medications 4 to 6 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 8 revealed on December 28, 2024, medications were administered late. Resident 8 was scheduled to receive 8 medications at 8:00 AM. Resident received medications 8 1/2 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 9 revealed on December 28, 2024, medications were administered late. Resident 9 was scheduled to receive 19 medications between 8:00 AM and 10:00 AM. Resident received medications 4 to 6 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 10 revealed on December 28, 2024, medications were administered late. Resident 10 was scheduled to receive 12 medications between 8:00 AM and 12:00 PM. Resident received medications 2 to 5 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 11 revealed on December 28, 2024, medications were administered late. Resident 11 was scheduled to receive 5 medications at 8:00 AM. Resident received medications 6 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 12 revealed on December 28, 2024, medications were administered late. Resident 12 was scheduled to receive 11 medications between 8:00 AM and 9:00 AM. Resident received medications 8 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 13 revealed on December 28, 2024, medications were administered late. Resident 13 was scheduled to receive 13 medications between 8:00 AM and 12:00 PM. Resident received medications 3 to 8 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 14 revealed on December 28, 2024, medications were administered late. Resident 14 was scheduled to receive 20 medications between 8:00 AM and 12:00 PM. Resident received medications 2 to 7 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 15 revealed on December 28, 2024, medications were administered late. Resident 15 was scheduled to receive 11 medications between 8:00 AM and 9:00 AM. Resident received medications 4 to 5 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 16 revealed on December 28, 2024, medications were administered late. Resident 16 was scheduled to receive 6 medications between 8:00 AM and 9:00 AM. Resident received medications 8 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 17 revealed on December 28, 2024, medications were administered late. Resident 17 was scheduled to receive 12 medications between 8:00 AM and 12:00 PM. Resident received medications 4 to 5 hours later than scheduled per documentation in the MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record for Resident 18 revealed on December 28, 2024, medications were administered late. Resident 18 was scheduled to receive 7 medications at 8:00 AM. Resident received medications 4 to 5 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 19 revealed on December 28, 2024, medications were administered late. Resident 19 was scheduled to receive 13 medications between 8:00 AM and 12:00 PM. Resident received medications 3 to 8 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 20 revealed on December 28, 2024, medications were administered late. Resident 20 was scheduled to receive 4 medications at 8:00 AM. Resident received medications 2 1/2 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 22 revealed on December 28, 2024, medications were administered late. Resident 22 was scheduled to receive 19 medications at 8:00 AM. Resident received medications 3 to 3 1/2 hours later than scheduled per documentation in the MAR. A review of the clinical record for Resident 23 revealed on December 28, 2024, medications were administered late. Resident 23 was scheduled to receive 5 medications between 8:00 AM and 2:00 PM. Resident received medications 2 to 6 hours later than scheduled per documentation in the MAR. The Nurse Practitioner was notified regarding the late medication administrations on December 30, 2024, but was not notified on December 28, 2024. The following is a written statement from the Nurse Practitioner, On Monday, 10/30/2024, I was informed that an incident at the facility occurred on 10/28/2024 of possible medications not being administered to residents. All residents had no adverse reactions, therefore no further adjustments to treatment was required. During an interview with the Director of Nursing and Nursing Home Administrator (NHA) on January 7, 2024, both agreed that treatments and medications should be administered as ordered and that medications should not be signed off until completed. The NHA did inform the surveyor that the nurse who was assigned to the residents was terminated. 28 Pa. Code 211.12(c)(d)(1)(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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 33305 Based on clinical record review and staff interviews, it was determined the facility failed to ensure pain management was provided that was consistent with professional standards of practice for two of 23 residents reviewed (Residents 9 and 14). This failure resulted in actual harm to Residents 9 and 14, whose pain was not properly relieved and managed and continued to experience uncontrolled pain. Findings include: Review of the clinical for Resident 9 revealed diagnoses that included Polyneuropathy (peripheral nerve disorder that affects multiple nerves throughout the body simultaneously) and Chronic Pain Syndrome (persistent pain that lasts for weeks to years). Review of Resident 9's quarterly Minimum Data Set (MDS-periodic assessment of needs) revealed a BIMS score (brief interview of cognitive status) of 12, indicating moderate cognitive impairment. Review of Resident 9's care plan, last review date December 1, 2024, revealed a focus area to receive narcotics related to chronic pain syndrome with an intervention to administer pain medications as ordered. In a grievance filed by Resident 9 on December 28, 2024, Resident 9 stated that he/she had to request their routine morning pain medications. Resident 9 stated that he/she laid in pain all day. Clinical record review for Resident 9 revealed a physician's order dated December 20, 2024, for the Resident to be administered Methadone (a medication used to treat moderate to severe pain) 10 milligrams (mg), two tablets twice a day. On December 28, 2024, Methadone was ordered to be administered at 8:30 AM, but the Resident didn't receive the medication until 4:50 PM based on the medication administration audit (time medication administered in electronic health record). Clinical record review for Resident 9 revealed a physician order dated December 13, 2024, for Lyrica (anticonvulsant that is used to treat nerve pain) 75 mg, two tablets twice a day. On December 28, 2024, Resident 9 was to receive the Lyrica at 9:00 AM, but didn't receive it until 4:51 PM based on the medication administration audit. Clinical record review for Resident 14 on January 7, 2025, revealed diagnoses that included Hypertension (high blood pressure) and Chronic Pain (persistent pain that lasts for weeks or years). Review of Resident 14's quarterly MDS revealed a BIMS score of 15, indicating cognition is intact. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 14's care plan, last review date November 26, 2024, revealed a focus area of at risk for alterations in comfort with interventions to advise Resident to request pain medication before pain becomes severe; evaluate pain characteristics, quality, severity, location, precipitating/relieving factor; medicate Resident as ordered for pain and monitor for effectiveness, side effects, report to physician as indicated. Clinical record review for Resident 14 revealed a physician order dated December 3, 2024, for Tramadol 50 mg (opioid to treat moderately severe pain) that may be administered every 8 hours as needed for pain level 4-10. In a written statement filed by Resident 14 on December 28, 2024, the Resident requested her pain medication at 12:00 PM, and, when not provided, she requested them again 2 hours later. A third request was made to another staff person who administered the pain medication upon request at 4:05 PM. The administration time was signed out at 4:05 PM on the controlled medication record. Resident 14's written statement included the following comment, I was considering going to the hospital since my pain was so bad. During an interview with the Director of Nursing (DON) on January 7, 2025, the grievances regarding pain were discussed with the DON and she agreed that pain medication should be administered timely. During an interview with the DON on January 8, 2025, the DON revealed that the Nurse Practitioner/Physician wasn't informed of the late administrations until Monday December 30, 2024. The nurse that delayed administrations of medications as prescribed was terminated as of December 28, 2024. The facility failed to ensure pain medications were administered at the prescribed time, resulting in pain and suffering for Resident 9 and Resident 14 on December 28, 2024. 28 Pa. Code 211.2 (d)(9)(10) Medical director 28 Pa. Code 201.18(b)(1) Management 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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 33305 Based on clinical record review, staff interview, and Resident's written statement, it was determined that the facility failed to follow accepted professional standards and principles for administering medications to ensure the prevention of significant medication errors for three of 24 residents reviewed (Resident 9, 10 and 14). This failure resulted in harm to Resident 9 and 14 who suffered pain from the omission of mediations. Findings include: Review of Resident 9's quarterly Minimum Data Set (MDS-periodic assessment of needs) revealed a BIMS score (brief interview of cognitive status) of 12 indicating moderate cognitive impairment. In a grievance filed by Resident 9 on December 28, 2024, Resident 9 stated that he/she had to request his/he routine morning pain medications. Resident 9 stated that he/she laid in pain all day. Clinical record review for Resident 9 revealed a physician's order dated December 20, 2024, for the Resident to be administered Methadone (a medication used to treat moderate to severe pain) 10 milligrams (mg), two tablets twice a day. On December 28, 2024, Methadone was ordered to be administered at 8:30 AM, but the Resident didn't receive the medication until 4:50 PM based on the medication administration audit (time medication administered in electronic health record). Clinical record review for Resident 9 revealed a physician order dated December 13, 2024, for Lyrica (anticonvulsant that is used to treat nerve pain) 75 mg, two tablets twice a day. On December 28, 2024, Resident 9 was to receive the Lyrica at 9:00 AM, but didn't receive it until 4:51 PM based on the medication administration audit (time medication administered in electronic health record). Review of Resident 10's clinical record revealed diagnoses that included epilepsy (neurological disorders that cause brief episodes of spasms, unresponsiveness a.k.a. seizures) and hypertension (high blood pressure). Review of Resident 10's physician orders included Phenobarbital tablets 16.2 mg (milligrams), take four tablets daily for seizures. The Resident also received Phenytoin 100 mg tabs, and two tabs are to be administered daily for epilepsy. Review of controlled drug record revealed that Resident 10 was not administered the phenobarbital medication on December 28, 2024. Resident 10 did receive the phenytoin on December 28, 2024. During an interview with the Director of Nursing (DON) on January 7, 2024, at approximately 11:00 AM, the DON informed the surveyor that the Phenobarbital was signed off as administered on the Medication Administration Record; however, the surveyor reviewed the controlled drug record count sheet that confirmed that the medication was never administered on December 28, 2024. Clinical record review for Resident 14 on January 7, 2025, revealed diagnoses that included Hypertension (high blood pressure) and Chronic Pain (persistent pain that lasts for weeks or years). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 14's quarterly Minimum Data Set (MDS-periodic assessment of needs) revealed a BIMS score (brief interview of cognitive status) of 15 indicating cognition is intact. Clinical record review for Resident 14 revealed a physician order dated December 3, 2024, for Tramadol 50 mg (opioid to treat moderately severe pain) that may be administered every 8 hours as needed for pain level 4-10. In a written statement filed by Resident 14 on December 28, 2024, the Resident requested her pain medication at 12:00 PM, and, when not provided, she requested them again 2 hours later. A third request was made to another staff person who administered the pain medication upon request at 4:05 PM. The administration time was signed out at 4:05 PM on the controlled medication record. Resident 14's written statement included the following comment, I was considering going to the hospital since my pain was so bad. The Medication Administration Record revealed Resident 14 received the Tramadol on December 28, 2024, at 4:06 PM. During an interview with the Director of Nursing (DON) on January 7, 2025, she agreed that pain medication should be administered timely. The facility failed to administer scheduled pain medications per physcian order resulting in Resident 9 and 14 experiencing pain. 28 Pa. Code 211.12(d)(1)(5) Nursing services 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.9(c) Pharmacy services