

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Kingston Court Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46253</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage appropriately, in advance of changes for Medicare covered services, to one of three residents reviewed whose Medicare coverage was discontinued (Resident 341).</p> <p>Findings include:</p> <p>Review of Resident 341's clinical record revealed the Resident was readmitted to the facility on [DATE], after a hospital stay and that their payor source was Medicare A. Skilled services ended on April 14, 2024, and Resident 341's payor source changed to Medicaid at that time, and Resident 341 remained in the facility.</p> <p>Resident 341 was issued a Notice of Medicare Non-Coverage (NOMNC- indicates when your coverage for care is set to end) on April 16, 2024.</p> <p>The Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN, a form provides information that as of a specific date Medicare coverage ends and the specific amount of financial liability passed onto the resident) could not be provided by facility to show that it was provided to Resident 341.</p> <p>During an interview with the Nursing Home Administrator on August 29, 2024, at 1:19 PM, he confirmed that the facility could not provide a copy of the SNF ABN for Resident 341, and confirmed that he would expect that to have been completed and kept on file in Resident 341's medical record.</p> <p>28 Pa. Code 201.29(c.3)(1) Resident rights</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46253</p> <p>Based on observations and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like environment for one of three dining areas and four of 77 resident rooms observed (Resident 60, 71, 94, and 114).</p> <p>Findings include:</p> <p>Observation of Resident 60's room on August 26, 2024, at approximately 11:20 AM, revealed that the plastic molding was peeling away from the wall and hanging under the heating/ air conditioning unit.</p> <p>Observation of Resident 71's room on August 26, 2024, at approximately 11:00 AM, revealed that the plastic molding was missing from the wall at the head of their bed.</p> <p>Observation of Resident 114's room on August 26, 2024, at approximately 11:45 AM, revealed gouges in the wall near the head of their bed.</p> <p>Observation of Heritage Dining Room on August 26, 2024, at approximately 12:25 PM, revealed a stationary dining chair that had a missing piece of vinyl from the seating surface.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 29, 2024, at 10:48 AM, the NHA indicated the necessary repairs or actions had been completed for Residents 60, 71, and 114, and that the chair had been removed from the Heritage dining room.</p> <p>During a final interview with the NHA on August 29, 2024, at 1:30 PM, the NHA indicated that there were no prior work orders entered for the identified concerns for Residents 60, 71, and 114, or the Heritage dining room chair. He said that he would expect maintenance to identify environmental concerns on their rounds.</p> <p>Observation in Resident 94's room on August 26, 2024, at 10:08 AM, revealed he had nails sticking out of his wall between the windows in his room.</p> <p>During an interview with the NHA on August 28, 2024, at 10:21 AM, the surveyor revealed the environmental concern of nails sticking out of the wall in Resident 94's room.</p> <p>Follow-up interview with the NHA on August 29, 2024, at 10:39 AM, revealed the nails in the wall had been removed and that they were there from a previous resident who resided in that room. He further revealed he was unable to locate documentation to indicate a work order was submitted to remove the nails from the wall prior to surveyor inquiry.</p> <p>28 Pa. Code 201.18(e)(2.1) Management</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46253</p> <p>Ensure each resident receives an accurate assessment.</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for two of 30 residents reviewed (Residents 36 and 119).</p> <p>Findings include:</p> <p>Review of Resident 36's clinical record revealed diagnoses that included cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) and dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Review of Resident 36's Annual MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) with the assessment reference date (last day of the assessment period) of August 14, 2024, revealed in Section P. Restraints and Alarms that Resident 36 was coded as receiving a limb restraint when in bed on a daily basis.</p> <p>Review of Resident 36's current physician orders failed to reveal an order for a limb restraint.</p> <p>During an interview with Employee 2 and the Nursing Home Administrator (NHA) on August 28, 2024, at 1:46 PM, Employee 2 confirmed that Resident 36 does not have an order for a limb restraint and that the MDS was coded in error.</p> <p>During a final interview with Employee 2 and the NHA on August 29, 2024, at 11:12 AM, the NHA confirmed that he would expect a resident's MDS to be coded accurately.</p> <p>Review of Resident 119's clinical record revealed diagnoses that included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning that it interferes with a person's daily life and activities) and dysphagia (difficulty swallowing).</p> <p>Review of Resident 119's Quarterly MDS, with an assessment reference date of June 18, 2024, revealed in section K0300. Weight loss - loss of 5% or more in the last month or loss of 10% or more in the last 6 months, was marked no, indicating that weight loss did not occur.</p> <p>Review of Resident 119's clinical record revealed monthly weights to include Resident 119 weighing 111 pounds on June 17, 2024, and on May 6, 2024, Resident 119 weighed 121 pounds, which is a 9.01 % weight loss. On December 8, 2023, Resident 119 weighed 135.4 pounds, which is an 18.02 % weight loss compared to their weight of 111 pounds on June 17, 2024.</p> <p>During an interview with the NHA on August 29, 2024, at approximately 10:00 AM, revealed the Quarterly MDS for Resident 119 on June 18, 2024, was coded inaccurately and should have reflected their significant weight loss.</p> <p>28 Pa. Code 211.5(f) Clinical records</p>		

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<p>F 0642</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a qualified health professional conducts resident assessments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33879</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to coordinate the resident assessment for one of four discharged residents reviewed (Resident 110).</p> <p>Findings include:</p> <p>Review of Resident 110's clinical record revealed diagnoses that included hypertension (elevated/high blood pressure) and multiple sclerosis (disease of the central nervous system that damages the nerves, resulting in possible vision loss, pain, fatigue, loss of ability to speak, walk, and control motor movements).</p> <p>Review of Resident 110's clinical record revealed Resident 110 was admitted to the facility on [DATE].</p> <p>Review of Resident 110's clinical record revealed that on May 31, 2024, Resident 110 left the facility against medical advice (AMA).</p> <p>Review of the history of Minimum Data Set (MDS - standardized assessment tool utilized to identify a residents physical, cognitive and psychosocial needs) revealed that as of August 26, 2024, the facility did not complete a Discharge MDS.</p> <p>During a staff interview on August 29, 2024, at approximately 12:15 PM, Employee 11 (Registered Nurse Assessment Coordinator) confirmed that the Discharge MDS was not completed and that it was Missed.</p> <p>During a staff interview on August 29, 2024, at approximately 1:15 PM, Acting Director of Nursing revealed the Discharge MDS should have been completed for Resident 110 as a result of Resident 110 leaving the facility AMA on May 31, 2024.</p> <p>28 Pa code 211.12(d)(3) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46253</p> <p>Based on facility policy review, observations, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of 27 residents reviewed (Residents 6 and 94).</p> <p>Findings include:</p> <p>Review of facility policy, titled OPS214 Treatment: Refusal of, with a last revision date of March 1, 2022, revealed, in part: 1. If the patient refuses treatment, staff will determine what the patient is refusing and why. Staff will: 1.1 Try to address the patient's concern(s); 1.2 Consult his /her supervisor; 3. Notify physician of the refusal of the treatment; 4. Staff will 4.1 Determine and document what the patient is refusing; 4.2 Assess the reasons for the refusal; 4.3 Advise patient/HCDM [health care decision maker] of consequences of refusal; 4.4 Offer alternative treatments; and 6. Document discussions with the patient/HCDM, physician, and other involved persons.</p> <p>Review of Resident 6's clinical record revealed diagnoses that included bipolar disorder (a lifelong mood disorder and mental health condition that causes intense shifts in mood, energy levels, thinking patterns, and behaviors) and peripheral vascular disease (disease of the vascular system that results in decreased blood flow to the extremities).</p> <p>Review of Resident 6's current physician orders revealed an order to apply triple antibiotic to right lower leg and cover with border dressing one time a day for open wounds, dated August 18, 2024.</p> <p>Observation of Resident 6 on August 26, 2024, at 10:09 AM, revealed the presence of a dressing to their right lower leg that was dated August 19, 2024. The dressing had a moderate size area of a dark brown coloration noted.</p> <p>Observation of Resident 6 on August 27, 2024, at 9:51 AM, continued to reveal the presence of a dressing to their right lower leg that was dated August 19, 2024. The dressing had a moderate size area of a dark brown coloration noted.</p> <p>During an interview with Resident 6 during the observation, Resident 6 indicated that the Resident was having sharp pain there.</p> <p>Review of Resident 6's August Treatment Administration Record revealed that the treatment to their right lower leg was documented as being completed on August 19 and 20, 2024; and was documented as refused on August 21, 22, 23, 24, 25, and 26, 2024.</p> <p>During an observation of Resident 6 with Employee 1 (RN Supervisor/Unit Manager) on August 27, 2024, at 10:35 AM, Employee 1 confirmed that the dressing was dated August 19, 2024. Employee 1 was made aware that Resident 6 had voiced complaints of sharp pain to the area during surveyor's earlier observation. Employee 1 was also made aware that the treatment was documented as being last completed on August 20, 2024, and was documented as refusing on August 21-26, 2024. Employee 1 indicated that they would investigate the concern.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 6's clinical record progress notes failed to reveal any documentation that the staff nurse that had documented on the Treatment Administration Record as refused on August 21-26, 2024, had notified their supervisor. The progress notes also failed to reveal any documentation that Resident 6's physician had been made aware of their treatment refusals.</p> <p>During a follow-up interview with Employee 1 on August 27, 2024, at 10:45 AM, Employee 1 indicated that the Resident frequently refuses care and that they cannot make her agree to get dressing change. Employee 1 was made aware of the concerns that the current dressing had been in place for 8 days; Resident 6 was now complaining of pain to their right lower leg; there was no documentation of actions taken to address the treatment refusals or that Resident 6's physician was made aware of their refusals of the treatment; and the treatment was documented as completed on August 20, 2024, when it was not done as evidenced by the date on the current dressing. Employee 1 then indicated that Resident 6 also refuses medications at times as well. Surveyor again reiterated all identified concerns.</p> <p>During an interview with the Nursing Home Administrator (NHA) and Employee 2 (Registered Nurse Unit Manager/Acting Director of Nursing) on August 28, 2024, at 10:50 AM, the identified concerns for Resident 6 were shared for further follow-up.</p> <p>During a follow-up interview with the NHA and Employee 2 on August 28, 2024, at 1:44 PM, the NHA confirmed that he would expect clinical documentation to be accurate. He indicated that the Resident has a known history of refusing care and is care planned for such. He confirmed that the Resident 6's physician should have been made aware of their refusals of the ordered treatment. Employee 2 indicated that they should follow-up with Resident 6's physician to identify what time frame they would want notified of refusals of treatments and medications since this is a daily occurrence for this Resident.</p> <p>Review of Resident 94's clinical record revealed diagnoses that included include type 2 diabetes with hyperglycemia (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest in things), and muscle weakness.</p> <p>Review of Resident 94's physician orders revealed the following:</p> <p>Insulin Glargine-yfgn Subcutaneous Solution Peninjector 100 UNIT/ML (Insulin Glargine-yfgn) Inject 30 unit subcutaneously every morning and at bedtime for diabetes, with a start date of March 15, 2024, and discontinued on May 7, 2024.</p> <p>HumaLOG Solution 100 UNIT/ML Inject as per sliding scale: if 0 - 150 = 0 units (If blood glucose is less than 70, call MD); 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351+ = 10 units and (if blood glucose is greater than 400, call MD immediately for further instruction), subcutaneously with meals for sliding scale insulin coverage for diabetes, must take finger stick blood glucose prior to administration, with a start date of May 30, 2024, and discontinued on July 17, 2024.</p> <p>HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 5 unit subcutaneously three times a day for Dm use dexcom G7 continuous monitoring system sensor, with a start date of August 10, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Resident 94 on August 26, 2024, at 11:28 AM, revealed he is supposed to be on insulin, but it is not always received.</p> <p>Review of Resident 94's care plan revealed a focus area of, Risk for low cardiac out put related to history of Diabetes Mellitus, initiated March 26, 2024, with an intervention for Administer hypoglycemic medications as ordered, initiated March 26, 2024.</p> <p>Review of Resident 94's May 2024 MAR (Medication Administration Record- documentation for treatments/medication administered or monitored) revealed his morning dose of insulin glargine was not administered on May 5, 2024, with a reason that stated NN- No / See Nurse Notes.</p> <p>Review of Resident 94's clinical record failed to reveal a nurse's note indicating the rationale for why his aforementioned insulin was not administered.</p> <p>Review of Resident 94's June 2024 MAR revealed his 11:30 AM dose of Humalog was held on June 8, with a reason noting just gave insulin one hour ago.</p> <p>Review of Resident 94's July 2024 MAR revealed his 7:30 AM and 11:30 AM Humalog doses on July 4 were not documented as administered.</p> <p>Review of Resident 94's August 2024 MAR revealed his 12:30 PM Humalog dose on August 17 was not documented as administered.</p> <p>During an interview with Employee 2, in the presence of the NHA, on August 28, 2024, at 10:03 AM, the surveyor questioned why the 7:30 AM dose of insulin was just given prior to the 11:30 AM dose on June 8, and why Resident 94's insulin was not documented as administered at aforementioned times on May 5, July 4, and August 17.</p> <p>Follow-up interview with the Employee 2 on August 29, 2024, at 10:07 AM, revealed she was unable to provide rationale for why the insulin was administered late on June 8 and not documented as administered on the other aforementioned dates and times. No further information was provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(c)(d)(1)(2)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>46253</p> <p>Based on facility policy review, clinical record review, observations, and resident and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility received appropriate services, equipment, and assistance to maintain or improve mobility for two of three residents reviewed (Residents 8 and 60).</p> <p>Findings include:</p> <p>Review of facility policy, titled Restorative Nursing, last revised on August 7, 2023, read, in part, Restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. A licensed nurse must supervise the activities in the restorative nursing program. Purpose: to help the patient attain and maintain optimal physical, mental, and psychosocial functioning. Implement the restorative nursing program according to the specifics on the care plan. Document daily on restorative nursing record in PointClickCare ADL Point of Care.</p> <p>Review of Resident 8's clinical record revealed diagnoses that included muscle weakness, lack of coordination, and dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning).</p> <p>Interview with Resident 8 on August 26, 2024, at 9:58 AM, revealed he doesn't get out of bed much and he wishes he could get more therapy.</p> <p>Review of Resident 8's care plan revealed a focus area Restorative Range of Motion: Patient demonstrates loss of sitting tolerance cognitive loss/dementia, functional deterioration, last revised July 29, 2024, with an intervention for Have resident get up out of bed everyday in the AM for lunch for up to 4 hours using a hooyer lift, initiated on July 29, 2024.</p> <p>Further review of Resident 8's care plan revealed a focus area of Activities of daily living self-care deficit as evidenced by physical limitations related to traumatic brain injury post motorcycle accident, last revised August 29, 2023, with an intervention for Restorative Nursing: Upper body strengthening exercises to all planes of motion using Yellow Theraband; 10 reps 2x/day, initiated on December 7, 2023.</p> <p>Observations of Resident 8 on August 26, 2024, at 9:58 AM; August 27, 2024, at 11:27 AM; and August 28, 2024, at 9:16 AM and 11:16 AM; revealed he was not up out of bed.</p> <p>Review of Resident 8's nurse aid task, titled Restorative Program Bed Mobility: (Record self perform / support under Bed Mobility task) See care plan/kardex for program, failed to reveal documentation to indicate tolerance to the program or minutes captured.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Employee 13 (Clinical Lead/Resource Nurse), in the presence of the Nursing Home Administrator (NHA), on August 28, 2024, at 10:26 AM, she revealed the nurse aide task was entered into the system incorrectly, so the nurse aides were unable to document minutes and tolerance of the program, but it has been fixed.</p> <p>During a follow-up interview with Employee 2 (Registered Nurse Unit Manager/Acting DON), in the presence of the NHA, on August 28, 2024, at 1:29 PM, she revealed she would expect restorative minutes and tolerance to the program to be documented.</p> <p>Review of Resident 60's clinical record revealed diagnoses that included hemiplegia (paralysis of one side of body) and hemiparesis (muscle weakness on one side of the body) following cerebral infarction (a stroke-damage to the brain from interruption of its blood supply) affecting the left dominant side and muscle wasting.</p> <p>Review of Resident 60's Occupational Therapy Discharge Summary dated July 12, 2024, indicated that Resident 60 was to be on a Restorative Nursing Program for Range of Motion to bilateral upper and lower extremities (both arms and legs) during AM and PM cares.</p> <p>Review of Resident 60's care plan and kardex revealed the following intervention: Restorative Program ROM Active #1: See care plan/kardex for program description, undated, and Monitor for independence for BLE 3 sets x 10 reps for 3-4 times per week, dated July 25, 2024.</p> <p>Further review of Resident 60's clinical record and care plan/kardex failed to identify the actual program description that was indicated on Resident 60's Occupational Therapy Discharge Summary.</p> <p>Review of Resident 60's clinical record nurse aide task documentation failed to reveal any documentation that the Resident had received their Restorative Nursing Programs or how the Resident tolerated the programs.</p> <p>During an interview with the NHA and Employee 2 on August 29, 2024, at 1:24 PM, the NHA indicated that there was an error in how the restorative program was entered in the electronic health record and, therefore, the task did not trigger for staff to document the provision of the restorative nursing program. He confirmed that he would expect restorative nursing care measures to be provided as recommended and documented accordingly.</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48484</p> <p>Based on observation, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents, which resulted in actual harm, as evidenced by a skin tear to the posterior right lower extremity for one of 27 residents reviewed (Resident 46).</p> <p>Findings Include:</p> <p>Review of Resident 46's clinical record revealed diagnoses that included multiple sclerosis (a chronic progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord; symptoms include numbness, impaired speech, muscle coordination, blurred vision, and severe fatigue), muscle weakness, and unsteadiness on feet.</p> <p>Review of select facility report detailing the incident that occurred on August 5, 2024, read, in part; that during care last evening the resident was being assisted to the toilet via sit to stand (STS) lift with one assist by [Employee 4 (Nurse Aide)]. A nurse [Employee 5 (Licensed Practical Nurse- LPN)] was present but not assisting due to a lack of room in the bathroom. When STS lift was removed and care started, nurse aide noticed the resident leg developed a bubble of blood under her hand which popped causing a skin tear. LPN evaluated the area and called for [Employee 3 (Registered Nurse- RN Supervisor)] who decided to send the resident out for further treatment.</p> <p>Review of the facility investigation revealed a statement from Employee 4: [Resident 46] is a stand to sit lift, I was using the lift by myself, but my nurse was in the front of the door .When [Resident 46] was ready to go to bed, I was ready to use the lift again, I saw her leg wasn't straight, she was sitting on the toilet, I tried to put her legs straight with my hands, at this time, I felt her skin broken under my hands, I called my nurse over.</p> <p>Employee 5 wrote a statement that said: Writer in doorway of [Resident 46's] bathroom when [Employee 4] transferring [Resident 46] to the toilet using the STS lift. Bathroom too small to accommodate all three of us so writer did not enter the bathroom with nurse aide. Residents foot got caught in the lift second to her lack of flexibility and nurse aide bent down to assist residents foot positioning by lifting her lower leg in an effort to not have resident injure her leg on the lift itself. As she moved lower leg forward she realized that she felt a 'spongy type feeling' and released residents leg. Skin tear visible to right inner calf area. Writer stepped in to apply pressure and assess the wound. Supervisor made aware and she followed up with her own assessment and called the on call [provider].</p> <p>Review of Resident 46's clinical record revealed the following telehealth nurse practitioner note on August 5, 2024, at 10:50 PM, that stated, Chief complaint: Skin tear to right calf. History of Present Illness: [Resident 46] is [AGE] year-old, female who is being seen today for skin tear to right calf during care. Observed with some bleeding during video visit. Currently prescribed Eliquis. Appears to need stitches with a deep cut during video visit. Resident reported pain of leg. Was given [medicine for pain] recently.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Kingston Court Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Kingston Court York, PA 17402	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 46's progress notes revealed a note that stated the resident was sent to Hospital via ambulance on August 5, 2024, at 11:55 PM, for evaluation of laceration to right inner calf.</p> <p>Further review of progress notes revealed that Resident 46 returned from the hospital on August 6, 2024 at 7:30 AM with Steristrips (thin adhesive bandage to help close wounds as they heal) to the laceration and new treatment orders.</p> <p>Review of Resident 46's physician orders revealed the following:</p> <p>Cleanse skin tear to RLE (right lower extremity) with wound cleanser and apply rolled gauze QD (once daily) and PRN (as needed) for dislodgement, every evening shift and PRN, with a start date of August 6, 2024, and an end date of August 15, 2024.</p> <p>Cleanse skin tear to RLE with wound cleanser and apply Xeroform and wrap with rolled gauze QD and PRN for dislodgement every evening shift and as needed, with a start date of August 15, 2024, and an end date of August 16, 2024.</p> <p>Cleanse to RLE with wound cleanser and apply medihoney and cover with telfa and wrap with kling daily every evening shift for wound care, with a start date of August 17, 2024.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 28, 2024, at 9:26 AM, he revealed the facility suspended Employee 4 during the investigation, and brought her back after disciplinary action and education was provided. He stated that two nurses should have been utilizing the STS lift together during the transfer and that education was provided to all nursing staff; and that if they feel there is not enough room to use the STS lift in personal bathrooms, the common bathroom on the unit should be used.</p> <p>Review of the facility education revealed the subject of the education said, Every lift requires 2 people at all times.</p> <p>Observation of the STS lift on the unit on August 28, 2024, at 12:37 PM, failed to reveal leg straps or that it makes contact with the posterior calf area during normal use.</p> <p>During a phone interview with Employee 4 on August 28, 2024, at 3:20 PM, she revealed she placed Resident 46 on the toilet and when the Resident was ready to transfer back off of the toilet, Resident 46 told the aide her foot was numb and she needed assistance with her placement on the sit to stand lift. When Employee 4 placed her hand on the Resident's leg to help her position it on the lift, she felt her skin break under her hand, and that is when she called for the RN Supervisor to come and assess Resident 46's wound. She further revealed she knows the lift should be operated by two people and she was operating it by herself at the time due to limited space in the bathroom. She revealed she is able to successfully utilize the lift with two people despite tight space and has done so moving forward.</p> <p>During a follow-up interview with the NHA on August 29, 2024, at 10:40 AM, the surveyor revealed the concern with the lack of two person assist using the STS lift during care on August 5, 2024. No further information was provided.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48484</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on facility policy review, observations, clinical record review, and staff interviews, it was determined that the facility failed to provide respiratory care and services consistent with professional standards of practice for one of five residents reviewed for respiratory care/oxygen services (Resident 58).</p> <p>Findings include:</p> <p>Review of facility policy, titled Respiratory Equipment/Supply Cleaning/Disinfection, last revised June 1, 2021, revealed Policy: Cleaning and disinfection of respiratory equipment is performed by a respiratory therapist, licensed nurse, or equipment technician. All respiratory equipment which cannot be immersed in water is cleaned with a disinfecting solution and allowed to dry. Disinfection is performed on all equipment on a scheduled basis and upon discontinuation from service and between patients. Purpose: To remove microorganisms from the surfaces of equipment.</p> <p>Review of Resident 58's clinical record revealed diagnoses that included obstructive sleep apnea (OSA- a sleep-related breathing disorder that causes repeated disruptions in breathing during sleep), chronic kidney disease (a condition characterized by a gradual loss of kidney function), and muscle weakness.</p> <p>Review of Resident 58's physician orders revealed an order for CPAP at bedtime for sleep apnea, document if refused, with a start date of March 8, 2024.</p> <p>Observation in Resident 58's room on August 26, 2024, at 10:22 AM, revealed his CPAP mask was laying on the floor next to his bedside table.</p> <p>Observation in Resident 58's room on August 28, 2024, at 9:21 AM, revealed his CPAP mask was laying out on his bedside table.</p> <p>Review of Resident 58's TAR (Treatment Administration Record- documentation for treatments/medication administered or monitored), revealed documentation to indicate that he utilized his CPAP machine overnight prior to the mornings of August 26 and 28, 2024.</p> <p>Review of Resident 58's care plan on August 28, 2024, at 9:58 AM, failed to reveal notation that Resident 58 utilizes a CPAP machine.</p> <p>During a meeting with the acting Director of Nursing (DON) in the presence of the Nursing Home Administrator (NHA) on August 28, 2024, at 10:30 AM, the surveyor revealed the observations of Resident 58's CPAP mask on the floor and on the bedside table, not bagged or stored in a sanitary manner after use, and that his care plan failed to indicate he uses a CPAP machine.</p> <p>During a follow-up interview with the acting DON, in the presence of the NHA, on August 28, 2024, at 1:29 PM, she revealed that Resident 58's mask has been cleansed and bagged and she would expect it to be cleansed and bagged after each use. She further revealed she would expect him to have a care plan regarding his diagnosis of OSA with the need for CPAP machine use.</p> <p>(continued on next page)</p>		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.12 (d)(1)(2)(5) Nursing services

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>48484</p> <p>Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards, and failed to maintain complete and accurate records related to dialysis communication for one of three residents reviewed for dialysis (Resident 93).</p> <p>Findings include:</p> <p>Review of facility policy, titled Procedure: Dialysis: Home Hemodialysis (HHD), last revised January 8, 2024, read, in part, At completion of HHD, Center staff will report and document: Vital signs; Documentation will include: Pre-HHD assessment and vital signs; Condition of AV access site or catheter insertion site with date and time of dressing change; Dialysis facility staff will report to Center staff upon completion of HHD.</p> <p>Review of Resident 93's clinical record revealed diagnoses that included dependence on renal dialysis (a treatment for kidney failure that filters your blood and removes toxins, waste, and excess fluids), hypertension (high blood pressure), and hyperkalemia (high blood potassium).</p> <p>Review of Resident 93's physician orders revealed an order for Hemodialysis with a chair time: 10:30am Tues-Thurs-Sat Transportation via ambulance every night shift every Mon, Wed, Fri for Dialysis, with a start date of July 19, 2024.</p> <p>During an interview with Resident 93 on August 26, 2024, at 11:47 AM, she revealed she does not believe she has an emergency kit related to dialysis at her bedside.</p> <p>Interview with Employee 14 (Licensed Practical Nurse) on August 26, 2024, at 12:52 PM, revealed she is not aware of Resident 93 having an emergency dialysis kit at her bedside.</p> <p>Interview with Employee 2 (Registered Nurse Unit Manager/Acting DON) on August 26, 2024, at 1:25 PM, she revealed the facility policy only speaks to having hemostats (tools used to control bleeding) at bedside for residents with external chest port access; however, Resident 93 now has a hemostat by her bedside, and they will look into changing that process.</p> <p>During an interview with Employee 15 (Physician Assistant) on August 28, 2024, at 11:04 AM, the surveyor questioned where Resident 93's dialysis book with her communication sheets could be found, her response was that she didn't think she had one.</p> <p>Review of select facility dialysis communication sheets revealed the following:</p> <p>Dialysis communication sheet on June 1, 2024, failed to reveal documentation related to her AV shunt assessment at the facility post-dialysis.</p> <p>Dialysis communication sheet on June 4, 2024, revealed the dialysis center had failed to fill their section of the communication sheet.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dialysis communication sheet on June 6, 2024, failed to reveal documentation that vital signs were assessed at the facility pre-dialysis.</p> <p>Dialysis communication sheet on June 8, 2024, failed to reveal documentation that pre-dialysis temperature or pulse were assessed at the facility; and the dialysis center had failed to fill their section of the communication sheet.</p> <p>Dialysis communication sheet on June 11, 2024, failed to reveal facility documentation related to her AV shunt assessment pre-dialysis.</p> <p>Dialysis communication sheet on June 22, 2024, failed to reveal facility documentation that pre-dialysis temperature or pulse were assessed.</p> <p>Dialysis communication sheet on July 23, 2024, revealed the facility post-dialysis assessment data was dated July 25, 2024, and had the same information as her dialysis communication sheet from July 25, 2024.</p> <p>Dialysis communication sheet on July 25, 2024, failed to reveal documentation that pre-dialysis temperature or pulse were assessed at the facility.</p> <p>Dialysis communication sheet on July 30, 2024, failed to reveal pre or post-dialysis assessments at the facility.</p> <p>Dialysis communication sheet on August 8, 2024, failed to reveal documentation that pre-dialysis temperature or pulse were assessed at the facility.</p> <p>Dialysis communication sheet on August 10, 2024, revealed the dialysis center had failed to fill their section of the communication sheet.</p> <p>Dialysis communication sheet on August 15, 2024, failed to reveal facility documentation related to her AV shunt assessment post-dialysis, and the dialysis center had failed to fill their section of the communication sheet.</p> <p>Dialysis communication sheet on August 20, 2024, failed to reveal a facility post-dialysis assessment.</p> <p>Dialysis communication sheet on August 22, 2024, failed to reveal facility obtained pre-dialysis vital signs or a facility obtained post-dialysis assessment.</p> <p>Dialysis communication sheet on August 24, 2024, revealed the dialysis center had failed to fill their section of the communication sheet.</p> <p>During an interview with Employee 2, in the presence of the Nursing Home Administrator (NHA), on August 28, 2024, at 1:27 PM, she revealed if dialysis does not fill their section of the communication sheet, she would call them and have them email the facility the results.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Follow-up interview with Employee 2, in the presence of the NHA, August 29, 2024, at 1:12 PM, revealed they were unable to locate the missing documentation from the communication sheets or that dialysis was contacted to email results of their part of the communication sheet on the aforementioned dates. No further information was provided.</p> <p>28 Pa code 211.5(f) Medical Records</p> <p>28 Pa Code 211.12(d)(1)(3)(5) Nursing Services</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>47966</p> <p>Based on clinical record review, facility policy review, and staff interviews, it was determined that the facility failed to provide a record of the pharmacist's recommendation along with the physician's response for one of five residents reviewed for unnecessary medications (Resident 119), and failed to act upon a pharmacy recommendation appropriately or in a timely manner for one of five residents reviewed for unnecessary medications (Resident 46).</p> <p>Findings include:</p> <p>Review of the facility policy, titled Medication Regimen Review (MRR) and Reporting, last reviewed January 2024, read, in part, Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or physician. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable format to nurses, physicians, and the care planning team within 48 hours of MRR completion. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. For recommendations that do not require physician intervention, the director of nursing or licensed designee will address the recommendations.</p> <p>Review of Resident 46's clinical record revealed diagnoses that included adjustment disorder with mixed disturbance of emotions and conduct (a disorder that causes excessive reactions to stress that involve negative thoughts, strong emotions, and changes in behavior), multiple sclerosis (a chronic progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord; symptoms include numbness, impaired speech, muscle coordination, blurred vision, and severe fatigue), and muscle weakness.</p> <p>Review of Resident 46's physician orders revealed the following:</p> <p>Abilify Oral Tablet 15 MG (Aripiprazole) Give one tablet by mouth at bedtime, with a start date of September 22, 2023, and discontinued June 26, 2024.</p> <p>Abilify Oral Tablet 15 MG (Aripiprazole) Give one tablet by mouth at bedtime, with a start date of June 26, 2024, and discontinued July 2, 2024.</p> <p>Abilify Oral Tablet 15 MG (Aripiprazole) Give 1 tablet by mouth at bedtime, with a start date of July 2, 2024, and discontinued August 6, 2024.</p> <p>Abilify Oral Tablet 10 MG (Aripiprazole) Give 10 mg by mouth at bedtime, with a start date of August 6, 2024, and discontinued August 8, 2024.</p> <p>Abilify Oral Tablet 10 MG (Aripiprazole) Give 10 mg by mouth at bedtime, with a start date of August 8, 2024, and completed date of August 29, 2024.</p> <p>(continued on next page)</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of MRR dated February 27, 2024, revealed Recommendation: Please reevaluate continued use [of antipsychotics] and consider a gradual dose reduction (GDR), under Please provide CMS required patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in this individual, the physician responded Following with Meditelectare, they will determine if GDR is advisable.</p> <p>Review of Resident 46's clinical record failed to reveal a GDR of her antipsychotic medication had been implemented since the pharmacy recommendation on February 27, 2024, until July 31, 2024, following an interdisciplinary meeting.</p> <p>Review of MRR dated June 22, 2024, revealed Recommendation category: Clinical monitoring request to follow prescription therapy. Please add antipsychotic monitoring to patient MAR. (MAR - Medication Administration Record- documentation for treatments/medication administered or monitored) The document failed to reveal the physician had reviewed the recommendation.</p> <p>Review of Resident 46's physician orders and MAR on August 27, 2024, failed to reveal an order for antipsychotic monitoring.</p> <p>During an interview with the Employee 2 (Registered Nurse Unit Manager/Acting DON), in the presence of the Nursing Home Administrator, on August 28, 2024, at 1:25 PM, she revealed the antipsychotic monitoring on the MAR is a newer process and they are working on that process, but she would expect the recommendation from pharmacy to be responded to and implemented timely.</p> <p>During an interview with Employee 2 on August 29, 2024, at 10:38 AM, she revealed Resident 46 was never followed by Meditelectare. The surveyor revealed the concern related to the February 27, 2024, pharmacy recommendation signed by the physician, indicating Meditelectare will determine if a GDR is advisable. No further information was provided.</p> <p>Review of Resident 119's clinical record revealed diagnoses that included dementia (the loss of cognitive functioning, thinking, remembering, and reasoning that it interferes with a person's daily life and activities) and dysphagia (difficulty swallowing).</p> <p>Review of Resident 119's clinical record revealed a medication regimen review completed by the pharmacist on February 27, 2024, that stated there were comment/recommendations noted by the pharmacist. Further review of Resident 119's record failed to reveal evidence of the recommendations made by the pharmacist on February 27, 2024, as well as evidence the physician responded to the recommendations.</p> <p>Interview with the acting Director of Nursing on August 28, 2024, at approximately 2:00 PM, revealed they were unable to locate the pharmacy recommendations or the physician's response from the MRR that was completed on Resident 119 on February 27, 2024.</p> <p>28 Pa Code 211.9(a)(1) Pharmacy Services</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing Services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40010</p> <p>Based on observation, facility policy, product information, and staff interviews, it was determined that the facility failed to store medication in accordance with professional principles for one of three medication storage rooms observed (Heritage Medication Storage Room).</p> <p>Findings Include:</p> <p>Review of facility provided policy, Medication Administration General Guidelines, effective [DATE], revealed, No expired medication will be administered to a resident.</p> <p>Observation of the Heritage Medication Storage Room on [DATE], at 9:15 AM, revealed one single-dose vial of Aranesp (medication used to treat low red blood cell count) 40mcg/1ml. The vial was open with the cap removed and no opened date on the vial.</p> <p>Review of Aranesp product information on [DATE], revealed that Aranesp is only available in single dose vials. Further review revealed once opened Aranesp should only be used one time. Throw the vial away after use even if there is medicine left in the vial.</p> <p>Interview with Employee 1 (Registered Nurse Supervisor) on [DATE], at 10:15 AM, in response to the question of how long the medication is good after it is opened, revealed that the facility uses the medication until the bottle is empty, as long as it is not past the expiration date on the bottle, because the Aranesp is too expensive to waste.</p> <p>Interview with Nursing Home Administrator on [DATE], at 1:35 PM, revealed an expectation that the medication would have disposed of after a single use and the manufacture guidelines should have been followed.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy services</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>33879</p> <p>Based on clinical record review, facility document review, and staff interviews, it was determined that the facility failed to document education regarding the influenza vaccination at the time of refusal for two of five residents reviewed for immunizations (Residents 46 and 85).</p> <p>Findings include:</p> <p>Review of facility influenza vaccination tracking revealed that Residents 46 and 85 had refused the 2023/2024 influenza vaccine.</p> <p>Review of available information revealed that the facility was unable to provide documentation that the facility provided education of the benefits and potential risks of not accepting the 2023/2024 influenza vaccination to Residents (or Resident Representative) 46 and 86.</p> <p>During an interview with the facility's Infection Preventionist on August 29, 2024, at approximately 1:00 PM, it was revealed that the facility could not locate documentation that education was provided to Resident 46. Further, it was revealed that the facility employee that documented Resident 85's influenza vaccination refusal was not aware that the Resident and/or Resident Representative was to receive education regarding the risks and benefits regarding the influenza vaccination or refusal thereof.</p> <p>During a staff interview on August 29, 2024, the Acting Director of Nursing revealed there should have been documented evidence that Residents/Resident Representative 46 and 85 were provided education at the time of the influenza vaccine refusal.</p> <p>28 Pa code 211.12(d)(1)(5) Nursing services</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395037	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Kingston Court Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Kingston Court York, PA 17402	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>46253</p> <p>Based on review of personnel training records and staff interview, it was determined that the facility failed to ensure each nurse aide was provided with the required in-service training consisting of no less than 12 hours per year for five of five nurse aide employee records reviewed (Employees 6, 7, 8, 9, and 10); failed to provide annual training that included dementia management and resident abuse prevention for one of five nurse aide employee records reviewed (Employee 7); and failed to provide annual training that included abuse prevention for one of five nurse aide employee records reviewed (Employee 6).</p> <p>Findings Include:</p> <p>Review of personnel information revealed Employee 6's hire date was November 28, 2014; Employee 7's hire date was March 9, 2023; Employee 8's hire date was February 1, 2023; Employee 9's hire date was April 4, 2023; and Employee 10's hire date was December 10, 2022.</p> <p>Review of facility training records failed to reveal that the aforementioned Employees completed 12 hours of required annual training in the past 12 months.</p> <p>Further review of facility training records failed to reveal evidence that dementia management or abuse prevention training was completed by Employee 7 within the past 12 months.</p> <p>Further review of facility training records failed to reveal evidence that dementia management training was completed by Employee 6 within the past 12 months.</p> <p>During an interview with the Nursing Home Administrator (NHA) on August 29, 2024, at 12:48 PM, the NHA indicated that the former Director of Nursing used to keep copies of staff education files in a binder, but he could not locate the binders. He confirmed that he had no additional information to provide other than the corporate reports of staff education completion, and he confirmed that he would expect nurse aides to complete their annual required training topics and hours.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management</p> <p>28 Pa. Code 201.19 (7) Personnel policies and procedures</p> <p>28 Pa. Code 201.20(a)(d) Staff development</p>