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	09/11/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and staff interviews, it was determined that the facility failed to ensure residents are treated with respect and dignity and cared for in a manner and in an environment that promotes dignity for one of one meals observed (lunch on September 9, 2025).Findings include: Observation of tray line service on September 9, 2025, at 11:56 AM, some residents were served the peach cobbler in plastic thermal bowls and others in Styrofoam bowls. Additionally, some residents were provided with reusable plastic tumblers while other residents were served a disposable plastic cup. During an interview with the Employee 1 (Food Service Director) on September 9, 2025, at 12:11 PM, it was revealed there aren't enough bowls and cups to serve all residents during the meal and, therefore, they utilize Styrofoam bowls and disposable plastic cups for some residents. During an interview with the Nursing Home Administrator (NHA) on September 10, 2025, at 1:50 PM, it was revealed that reusable thermal bowls were ordered, however, the order needed to be submitted to a different purveyor, and she had to verify the cups were ordered. During an interview with the NHA on September 11, 2025, at 11:30 AM, it was revealed that the facility should have enough bowls and cups to serve all residents. 28 Pa code 201.29(d) - Resident Rights

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 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, policy review, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, comfortable, and home-like environment in resident rooms on two of six nursing units (Heritage and A station).Findings include:Review of facility policy, titled Environmental Services Policies and Procedures, last reviewed June 18, 2025, read, in part, All resident/patient areas are cleaned at least daily and include resident/patient rooms.Review of July 2025 Resident Council Minutes revealed there were resident complaints of dirty rooms. Review of the April 2025 facility grievance log listed concerns from three residents (Residents 103, 138, and 144) that had housekeeping concerns regarding resident rooms not being clean and floors in resident rooms and bathrooms not being clean.Observation in Resident 3's room on September 8, 2025, at 10:48 AM, revealed the floor in her room was dirty, the floor under her bed was dirty, there was a collection of grey fuzzy substance in the corner under a chair, and there was a piece of cereal in the corner. Observation in Resident 3's room on September 9, 2025, at 10:08 AM, revealed the floor in her room was dirty, the floor under her bed was dirty, there was a collection of grey fuzzy substance in the corner under a chair, and there was a piece of toasted o cereal and an empty medicine cup in the corner. Observation in Resident 3's room on September 10, 2025, at 10:04 AM, revealed the floor in her room was dirty, the floor under her bed was dirty, there was a collection of grey fuzzy substance in the corner under a chair, and there was a piece of cereal in the corner. During an interview with Resident 3 on September 10, 2025, at 10:04 AM, she revealed the facility staff does not clean her room as well as she would like them to, and they never move the chair in the corner to clean underneath the chair.During an interview with the Nursing Home Administrator (NHA) on September 10, 2025, at 2:10 PM, the surveyor revealed the observations and concerns with Resident 3's room.Interview with the NHA on September 11, 2025, at 11:14 AM, it was revealed Resident 3's room had been cleaned, and she would expect residents to have a clean, comfortable, homelike environment. During an interview with Resident 101 on September 9, 2025, at 10:20 AM, it was revealed the room is not cleaned routinely. The floors and the bathroom are only cleaned twice a week, and they never clean under the dresser or dust the tops of the dresser. When cleaning the bathroom, it takes them less than five minutes to clean it.Observation on September 9, 2025, at 10:28 AM, and September 10, 2025, at 10:30 AM, revealed the bathroom walls contained a dark grey fuzzy substance that was able to be wiped with a paper towel, the floor along the baseboard had a brown film, the wall above the towel bar had two patches on the wall that were not smooth and lacking paint, the fan vent on the ceiling had a dark grey fuzzy substance, and a white streak on the wall tile to the right of the toilet which was able to be wiped with a moist paper towel. In the resident room the television contained a dark grey fuzzy substance, and under the dressers the floor contained a thick black film. The privacy curtain had several areas of dried light brown liquid on the curtain.During an interview with the NHA on September 10, 2025, at 2:09 PM, the surveyor revealed the observations and concerns with Resident 101's room.During an interview with the NHA on September 11, 2025, at 11:15 AM, it was revealed Resident 101's room had been cleaned. It was further revealed that she would expect a clean and comfortable home-like environment. Observation in Resident 135's room on September 8, 2025, at 10:57 AM; September 9, 2025, at 10:09 AM; and September 10, 2025, at 10:05 AM, revealed the floor in her room was dirty, and the wallpaper behind her bed was ripped. During an interview with the NHA on September 10, 2025, at 2:10 PM, the surveyor revealed the observations and concerns with Resident 135's room.Interview with the NHA on September 11, 2025, at 11:14 AM, she revealed Resident 135's room had been cleaned and the wallpaper was being repaired by maintenance staff, and she would expect residents to have a clean, comfortable, homelike environment. 28 Pa. Code 201.18 (e)(2.1) Management

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to review and revise the care plan for two of 27 residents reviewed (Resident 7 and 135).Findings include:Review of facility policy, titled Person-Centered Care Plan, last reviewed June 18, 2025, read, in part, The care plan will be reviewed and revised by the interdisciplinary team after each assessment.Review of Resident 7's clinical record revealed diagnoses that included congestive heart failure (a chronic condition in which heart doesn't pump blood as well as it should) and gastroesophageal reflux disease (GERD-a digestive disease in which stomach acid or bile irritates the food pipe lining).Review of Resident 7's care plan under the focus area for gastrointestinal symptoms revealed an intervention that stated, encourage resident to discuss feelings regarding ostomy (a surgically created opening in the abdomen that reroutes bodily waste, like urine or stool, from its usual path into a prosthetic pouch on the outside of the body).Further review of Resident 7's clinical record revealed the Resident never had an ostomy or had any risk of having an ostomy.During an interview with the Director of Nursing (DON) on September 11, 2025, at 11:30 AM, the DON confirmed Resident 7 never had an ostomy and that the care plan should have been revised to remove this intervention that was entered erroneously on July 7, 2024.Review of Resident 135's clinical record revealed diagnoses that included type 2 diabetes mellitus with hyperglycemia (DM- a metabolic disorder in which the body has high sugar levels for prolonged periods of time), cerebrovascular accident (CVA- occurs when blood flow to a part of the brain is disrupted, either by a blockage or bleeding), and localized edema (fluid retention). Review of Resident 135's physician orders revealed the following orders that had been discontinued: Clopidogrel Bisulfate (Plavix) Oral Tablet 75 MG, Give 75 mg by mouth one time a day, with a discontinued date of December 13, 2022. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 5 unit subcutaneously at bedtime for DM, with a discontinued date of October 10, 2023.Review of Resident 135's care plan revealed focus areas of The resident is on insulin related to diabetes and The resident is on Anticoagulant therapy related to CVA- Plavix, both with a start date of April 30, 2018.Interview with the DON on September 10, 2025, at 2:11 PM, the surveyor questioned the active care plans for insulin and Plavix, as Resident 135 is no longer receiving those medications. During an interview with the DON on September 11, 2025, at 11:12 AM, she revealed she revised the care plan for Resident 135 to indicate she does not receive insulin or Plavix. 28 Pa. Code 211.10(a) Resident Care Policies

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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. Based on facility policy, review of the clinical record, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice that meet each resident's physical, mental, and psychosocial needs for one of 27 residents reviewed (Resident 101).Findings include: Review of facility policy, Administration of Medications and Treatments, revised August 1, 2016, read, in part, residents shall receive medication ordered by an authorized licensed practitioner at the correct time. Review of Resident 101's clinical record documented diagnoses that included diabetes mellitus (the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine). Interview with Resident 101 on September 9, 2025, at 10:24 AM, revealed at times, she received insulin and, at times, her blood sugar is checked after meals. Review of resident 101's physician orders included Humulin (long-acting insulin) 20 units one time a day, started August 29, 2025 and Humulin 16 units one time a day, started July 9, 2025, and discontinued August 28, 2025. Review of Resident 101's Medication Administration Record 2025 documented Humulin was scheduled to be administered at 8:00 AM, and on the following dates the medication was administered late: September 10th at 9:59 AM; August 3rd at 10:14 AM; August 10th at 10:30 AM; August 16th at 10:00 AM; August 24th at 9:34 AM; August 31st at 10:19 AM; July 12th at 10:37 AM; July 13th at 9:29 AM; and July 21st at 11:08 AM. Interview with the Director of Nursing (DON) on September 11, 2025, at 11:30 AM, it was revealed that she should expect the medication would be administered on hour before or an hour after the medication was scheduled to be administered. Email communication with the DON on September 11, 2025, at 12:33 PM, revealed no rational for the late administration of Humulin. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(a)(c) Resident care policies

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on review of the clinical record, policy review, and resident and staff interviews, it was determined that the facility failed to ensure pain management is provided in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of 30 residents reviewed (Resident 143).Findings include:Review of facility policy, administration of medications and treatments, last revised August 1, 2016, failed to reveal any expectation for a timeframe when meds are to be given around the time that they are ordered.Review of Resident 143's clinical record revealed diagnoses that included displaced fracture of lateral malleolus of right fibula (fracture of the ankle) and unspecified fracture of the upper end of the right tibia (fracture of the shin bone).Review of Resident 143's physician orders revealed an order for Gabapentin (medication used to treat nerve pain) 800 mg four times daily at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM for neuropathy (pain caused by nerve damage).Review of Resident 143's care plan revealed a focus area of, Resident exhibits or is at risk for alterations in comfort related to multiple fractures and a history or migraines, with an intervention of, medicate Resident as ordered for pain and monitor for effectiveness and monitor of side effects.Review of Resident 143's electronic medical record revealed that on September 6, 2025, her 8:00 AM dose of Gabapentin 800 mg was given at 10:50 AM, and the 12:00 PM dose of Gabapentin was given at 2:28 PM. Further review revealed that on September 7, 2025, her 8:00 AM dose of Gabapentin 800 mg was given at 10:32 AM, and the 12:00 PM dose of Gabapentin was given at 2:26 PM.Interview with Resident 143 on September 8, 2025, at 9:45 AM, revealed that over the weekend on September 6 and 7, 2025, she had received her morning pain medication over 2 hours late even though she was ringing her call bell to notify staff that she was in pain and needed her medication and that it was late.Interview with the Director of Nursing on September 11, 2025, at 11:30 AM, revealed that they don't have a policy regarding what timeframe that meds should be given, but she would expect them to be given in the timeframe an hour before until an hour after they are ordered to be given.28 Pa. Code 211.12(d)(1) Nursing services.28 Pa. Code 211.12(d)(3) Nursing services.28 Pa. Code 211. 12(d)(5) Nursing services.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on review of select food service committee meeting minutes, staff and resident interviews, observation, and completion of one meal test tray, it was determined that the facility failed to provide foods that are palatable, attractive, and at appetizing temperatures. Findings include: Review of resident council meeting minute dated July 8, 2025, revealed condiments were missing from select menu options, items being missed on resident trays, cooks are inconsistent with cooking the meals, hamburgers were hard, baked ziti was dry, and portion sizes are small for some items. Review of the Resident Council Meeting minutes dated August 12, 2025, revealed concerns with hot food temperatures, vegetables not fully cooked, tough meat, and portion of soup is a half bowl. Interviews with Residents 3, 68, and 101 during the initial pool process revealed concerns regarding the quality, flavor, texture, and temperature of food. During an interview with Resident 3 on September 8, 2025, at 10:58 AM, she revealed the food was terrible and lacks flavor. During a resident interview conducted on September 9, 2025, at approximately 9:30 AM, Resident 68 provided that she felt the food was often cold and not palatable. Interview with Resident 101 on September 9, 2025, at 10:19 AM, it was revealed concerns with the temperature of the hot food, small portion sizes of toast, not receiving items per her request that are listed on her tray ticket, and that the meat is tough. Review of facility provided Test tray evaluation form, not dated, read, in part, hot entree, starch and vegetable should be greater than 140 degrees Fahrenheit (F). A test tray completed on September 9, 2025, revealed the temperature of the turkey, brussels sprouts and mashed potatoes weren't palatable for temperature. The test tray was placed on a meal cart and delivered to 300 unit with other trays being delivered at that time; 19 minutes had elapsed between the time the test tray was prepared from the service line and presented for evaluation. Employee 1 (Food Service Manager) took temperatures of the food items at the time the test tray was served for evaluation (12:35 PM). The following were the recorded highest temperatures: roast turkey 136 Fmashed potatoes 139 Fbrussels sprouts 125.6 F peach cobbler was missing from the tray, but was served to residents at room temperatureiced tea 50.5 F Interview with Employee 1 revealed that the hot food items should be above 140 F, and the cold beverage should be less than 55 F. It was also noted that there should've been a dessert on the meal tray. During an interview with the Nursing Home Administrator on September 10, 2025, at 1:50 PM, it was revealed that meal temperatures would be acceptable and tray tickets should be followed. 28 Pa. Code 201.14(a). Responsibility of licensee

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, review of facility policy, and staff interviews, it was determined that the facility failed to store and serve food/beverages in accordance with professional standards for food safety in the kitchen area and two of three nourishment pantries (stations A and B).Findings include: Review of facility policies, Dry Storage and Refrigeration/Frozen storage, dated May 1, 2023, read, in part, routine cleaning procedures are followed. Food stock is dated on the day of receipt. items removed from the original box are individually dated. Dry bulk items are labeled with product name and date opened. Open packages are stored in closed containers, tightly secured with ties or in food quality storage bags. All foods are labeled with the name of the product, date received and use by date once opened. Individual shakes are labeled with sell by date when removed from the original container. Observation in the walk-in refrigerator on September 8, 2025, at 6:35 AM, revealed sliced turkey wrapped in plastic wrap not labeled or dated; and one bag grated cheese open and not securely closed or dated . In plastic thermal bowls that were not covered or dated were 2 tossed salads and 3 bowls puree red substance. Interview with Employee 1 (Food Service Director) on September 8, 2025, at 7:00 AM, it was revealed that the aforementioned items should be labeled and date marked. Observation in the prep area on September 8, 2025, at 6:37 AM, revealed: plastic container of bulk brown sugar not date marked, and the shelf with the bulk bins splattered with dried food. Under the toaster, one bag raisin bread not securely closed. The blender base was caked with dried food, and the oven contained a thick layer of a charred black substance on the inside. The three top covers to the plate warmer were broken (just laying on top). The shelf under the flat top grill contained one fry pan, one deep full pan and two lids that were visibly dirty with dried food and coagulated oil. Observation on the baker's rack was a pan 1/4 full of coffee cake dated September 8th that wasn't securely covered, one sheet of parchment paper was lying across the top. Additional observation September 9th, 2025, at 11:56 AM, revealed the ceiling above the tray line the vents and frame around the light contained a black fuzzy substance. Interview with Employee 1 on September 8, 2025, at 7:09 AM, it was revealed that bulk items should be date marked, the aforementioned areas are on a cleaning schedule, the top covers to the plate warmer have been broken for a while and Employee 1 was unsure if a maintenance request was submitted. It was also revealed that the items below the flat top should be cleaned. Observation on September 8, 2025, at 6:40 AM, revealed several baseboard tiles missing, grout missing on the floor in several areas, and the ceiling contained a dark grey fuzzy substance. Interview with Employee 1 on September 8, 2025, at 7:12 AM, it was revealed she wasn't sure who's job it was to clean the ceiling, and that she wasn't sure if the floor tiles are grout were scheduled to be repaired. Observation of the steam table on September 8, 2025, at 6:42 AM, revealed dried food dripped down the front of the unit and a potato wedge was on the bottom shelf. Observation in the reach-in refrigerator on September 8, 2025, at 6:43 AM revealed five Styrofoam bowls of diced peaches, one thermal bowl of diced peaches and seven portion-controlled cups of brown sugar weren't dated; and a second bowl of pudding not securely closed dated September 2nd, 2025, with no use by date. Two 46 oz mild thick lemon water and two 46 oz moderately thick lemon water were open with contents partially removed and not dated when opened or with a use by date. Interview with Employee 2 (Diet Aide) revealed there should be a sticker on the aforementioned items, marked when open and with a use by date. Interview with Employee 1 on September 8, 2025, at 7:14 AM, revealed the aforementioned items should be securely closed and date marked. Observation in B station nourishment pantry on September 8, 2025, at 7:36 AM, revealed 1 vanilla mighty shake was thawed and not date marked (the product should be used within 14 days of thawing). Interview with Employee 1 revealed the shake should have a snack label on it with a date. Observation in A station nourishment pantry on September 8, 2025, at 7:40 AM, revealed the inside of the microwave contained dried splattered brown substance. A direct interview with Employee 1 revealed the microwave should be cleaned or replaced and was unsure who was responsible for cleaning it. During an interview with the Nursing Home Administrator (NHA) on September 10, 2025, at 1:50 PM, it was revealed that items should be date marked when opened or pulled from the freezer, items should be stored off the floor and covered, and equipment should be clean. It was also stated that the plastic thermal bowls were ordered, however, the order needed to be submitted to a different purveyor, and she had to verify the cups were ordered. The tile and grout were in house to replace the floor in the dish room. The facility needed to schedule an evening/night to replace the floor. The facility anticipated that it would take one night and expect that the dish room would be utilized the next day as they are utilizing quick dry grout. 28 Pa code 211.6(f) -