

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on review of the facility's abuse prohibition policy, clinical records, and select investigative reports and staff interview it was determined that the facility failed to ensure that one resident out of 10 sampled was free from verbal abuse (Resident 2).</p> <p>Findings include:</p> <p>A review of the facility's Abuse policy last reviewed by the facility on March 2024, indicated that the objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detention and prevention. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability.</p> <p>A review of the clinical record revealed that Resident 2, was admitted to the facility on [DATE], with diagnoses, which included dementia.</p> <p>Review of Resident 2's quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 31, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview mental screen which evaluates cognitive ability) score of 1 (a score of 0-7 indicates severe, cognitive impairment), and required the assistance of two staff for bed mobility and toileting.</p> <p>Review of Resident 2's current care plan initially, dated January 11, 2023, indicated that the resident required the assistance of two staff for bed mobility and toileting.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility investigation report dated April 12, 2024, at 2 PM revealed that on Tuesday April 16, 2024 at 11 AM, Resident 2's personal companion, Employee 1 (employed by the resident's family) called the Nursing Home Administrator to report an incident that occurred on Friday April 12, 2024. She stated that there was a tall black aide (identified as Employee 2) that entered Resident 2's room at 2 PM after she rang the call bell because the resident had a bowel movement (BM). The aide came into the resident's room, while on her cell phone with ear buds in the aide's ears, using profanity on the phone to whomever she was speaking to while caring for Resident 2. Resident 2, who is hard of hearing and blind, asked the aide if she was speaking to her (the resident). The aide responded, per Employee 1 (companion) I don't need to speak to you to clean shit out of your vagina, I'm having a convo with my brother. Employee 1 (companion) stated that the aide repeatedly made comments about the resident being covered in shit while on the cellphone.</p> <p>The aide was not removed from the facility and suspended until Tuesday April 16, 2024, after the resident's companion notified the NHA. The employee was not prevented from having access to residents, at the time Employee 1 notified Employee 3, LPN, of the allegation of abuse on April 12, 2024, and continued to care for the resident victim.</p> <p>A review of a witness statement dated April 16, 2024, (no time indicated) Employee 1 (companion) stated, on Friday April 12, 2024, at approximately 2 PM Employee 2, a nurse aide, answered the resident's call light, on her phone (ear buds). The aide remained on her phone having a conversation with her brother using profanity. The resident became disoriented and upset and began yelling Are you talking to me?, What is going on? Employee 2 got in Resident 2's face and said I don't need to speak to you to clean shit out of your vagina, I'm having a convo with my brother. The resident responded stop breathing on me. The aide repeatedly made comments about the resident being covered in shit while on the phone. After the incident I (Employee 1, companion) told Employee 3 (LPN supervisor), Please don't ever send that aide (Employee 2) in the room again. Employee 3 (LPN supervisor) advised me to write statement. I declined for fear of retaliation. Later that night (April 12, 2024) around 7 P.M. I asked Employee 4 (RN Supr) if Employee 3 (LPN supervisor) told him not to let Employee 1, nurse aide, care for the resident. He said no, but will pass the message on. On Saturday April 13, 2024, at approximately 10 AM I arrived at the facility. Resident 2 asked who her aide was. The resident stated that the aide was not nice and barely fed her breakfast, but what she did feed her, did it forcefully and almost made her choke. I found out the aide was the same women from Friday (April 12, 2024, Employee 2 na). I reported the situation again to Employee 5 (RN Supr) who, at that time, removed Employee 1 from the resident's room for the remainder of the shift.</p> <p>Employee 1 (companion) again stated that she informed all the above noted nursing employees of the incident of verbal abuse of Resident 2.</p> <p>An interview conducted on April 16, 2024, (no time indicated) by the Nursing Home Administrator (NHA) and the Director of Nursing (DON) with Employee 3 (LPN Supr) revealed that this LPN stated that she was in Resident 2's room Friday April 12, 2024 after 2 P.M. She stated that nothing was reported to her concerning any reported abuse. She stated This (abuse) did not occur. I was never told there was any abuse to the patient and I do not believe this happened with the aide. The employee was then given a witness statement and told to write a more detailed statement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a written witness statement dated April 16, 2024, (no time indicated) Employee 3(LPN), revealed I was called into Resident 2's room in the afternoon (April 12, 2024) to look at Resident 2's toe. The resident's care taker (Employee 1, companion) began to tell me that she did not want the nurse aide that took care of her (Employee 2) to come back in the room, that she was scary. I was not told that she (nurse aide, Employee 2) was on her ear piece yelling at the resident and cursing. There was no abuse reported to me.</p> <p>A review of a witness statement dated April 16, 2024, (no time indicated), Employee 6 (LPN) stated that she worked on Friday April 12, 2024 3 PM to 11 PM shift. She stated that Employee 1 (companion) told her that evening that an aide was in her {Resident 2's } room on her cell phone cursing while providing care. She told me that the LPN charge nurse (Employee 3) was aware of the situation and wanted to ensure that the aide would not work on that hallway with Resident 2 again.</p> <p>A review of a telephone witness statement dated April 16, 2024, (no time indicated) from Employee 4 (RN supr, worked 7 A.M. to 7 P.M. Friday April 12, 2024) stated I texted Employee 7 (employee scheduler), that Employee 2 had been on her ear piece and phone and cursed while on the phone. I was told this by Employee 1 (companion) between 8 PM and 9 PM. She said nothing about abuse or anything.</p> <p>A review of a second telephone interview the facility conducted April 16, 2024, (no time indicated) with Employee 4 (RN Supr) indicated that I didn't think about calling the DON because Employee 1 (companion) said it was already taken care of by Employee 3 (LPN). I messaged Employee 7 (scheduler) to make sure she knew that Employee 1 (companion) did not want Employee 2 on that unit.</p> <p>A review of a telephone statement dated April 16, 2024, (no time indicated) revealed that Employee 6, LPN (who worked Friday April 12, 2024) revealed, Employee 1 (companion) told me that there was an aide today in her room (Employee 1), on her cell phone, cursing while providing care. She told me that Employee 3 (LPN) was ware of the situation and wanted to make ensure the aide Employee 2 was not working with Resident 2 anymore.</p> <p>A review of the first telephone statement dated April 16, 2024, (no time indicated) from Employee 7, LPN (who worked Saturday April 13, 2024, as the 7AM to 3 PM shift LPN) revealed that Employee 1 (companion) stated that on Friday April 12, 2024, Employee 2 was in Resident 2's room on her phone with her ear buds in, speaking to her boyfriend, using foul language. Employee 1 (companion) stated that on Friday April 12, 2024 Employee 2 was changing the resident and told the resident that she was full of shit and I'm cleaning it out of your vagina.</p> <p>A review of a second telephone interview dated April 16, 2024 (no time indicated) conducted with Employee 7 (LPN) during which Employee 7 stated I did not report it again because I was told by Employee 1 (companion) that the incident was already reported to Employee 3 (LPN) and taken care of.</p> <p>A review of a written witness statement dated April 16, 2024, (no time indicated) from Employee 8 (LPN) indicated that On Friday April 12, 2024, Employee 1 (companion) came to the nurses desk and asked where Employee 3 (LPN) was. I said she was taking care of something. Employee 3 (LPN) was notified by me that Employee 1 (companion) wanted to speak to her. Employee 3 (LPN) went to speak to Employee 1 (companion).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On Saturday April 13, 2024, Employee 1 (companion) reported I told Employee 3(LPN) that I did not want Employee 2 in Resident 2's room. Employee 1 stated Employee 2 is scary, she is dangerous. I asked why do you say that? Employee 1 (companion) stated she was on the phone when taking care of the resident and was cursing on the phone, I said, You told this to Employee 3 (LPN)? Employee 1 (companion) stated yes. Then said, This girl is going to kill someone. She is scary. I told Employee 1 (companion) that I would get the supervisor. Employee 1 (na) then said, Don't tell that girl (Employee 2) I said anything. I notified Employee 5 (RN Supr) and she went to talk to Employee 1 (companion).</p> <p>A witness statement dated April 16, 2024, (no time indicated) from Employee 2 stated On Friday April 12, 2024, I was assigned to Resident 2's room and was told I can not go into the room, so I only went into the room to change her in the morning and did not go into the room anymore that day. The only reason I was in the room to change her was because there were no aides that could change her at the time. This was before breakfast. I was told not to go back into the room around lunch time.</p> <p>There was no witness statement regarding the alleged incident that occurred Friday April 12, 2024. Employee 2's statement was referencing the following day, Saturday April 13, 2024.</p> <p>The facility investigation conclusion was noted as The abuse is unsubstantiated due to Resident 2 not being affected by the incident, the resident does not recall anything from the incident. Employee 2, a nurse aide, and Employee 3 (LPN) were not suspended until Tuesday April 16, 2024.</p> <p>According to the Centers for Medicare and Medicaid Services psychosocial outcome guide, application of reasonable person concept, considers the effect of the non-compliance on a reasonable person and the resident may consider the facility to be his/her home, where there is an expectation that he/she is safe, has privacy, and will be treated with respect and dignity.</p> <p>The resident trusts and relies on facility staff to meet his/her needs. The resident may be frail and vulnerable.</p> <p>The facility failed to apply the reasonable person concept, according to regulatory guidance, by stating that Resident 2 was not affected by the alleged verbal abuse.</p> <p>During an interview May 15, 2024 at approximately 1 PM, Employee 1 (companion) confirmed that verbal abuse occurred Friday April 14, 2024. She further confirmed that she informed the above noted nursing personnel on Friday April 12, 2024, and Saturday April 13, 2024, of the abuse. She stated that Resident 2 was affected by the incident. She stated that the resident has been more agitated since the incident.</p> <p>During a telephone interview on April 16, 2024 at approximately 10 AM, the resident's son stated that he was very upset about Employee 2's treatment of his mother. He stated that she had been more agitated since the incident.</p> <p>The facility failed to ensure Resident 2 was free from verbal abuse.</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>28 Pa. Code 211.12 (c)(d)(3)(5) Nursing Services</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.18 (e)(1) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on review of clinical records, the facility's abuse prohibition policy and staff witness statements, and staff and family interview, it was determined that the facility failed to timely and thoroughly investigate an allegation of resident abuse and prevent the potential for further abuse during the course of the investigation for one resident out of 10 resident sampled (Resident 2).</p> <p>Findings include:</p> <p>A review of the facility's Abuse prohibition policy last reviewed by the facility on March 2024, indicated that the objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detention and prevention. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within hearing distance, regardless of their age, ability to comprehend, or disability. It is the policy of this facility that reports of abuse are promptly and thoroughly investigated. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. Employees accused of abuse will be immediately removed from the facility and will remained removed pending the results of a thorough investigation.</p> <p>Review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnoses, which included dementia.</p> <p>Review of a Quarterly MDS assessment dated [DATE], revealed that the resident was severely cognitively impaired with a BIMS score of 1 (Brief Interview for Mental Status (BIMS) section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 1-7 equates to being severely, cognitively impaired) and required assistance of two staff for bed mobility and toileting.</p> <p>Review of Resident 2's current care plan, initially dated January 11, 2023, indicated that the resident required the assistance of two staff for bed mobility and toileting.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement dated April 16, 2024, (no time indicated) Employee 1 (companion) stated, on Friday April 12, 2024, at approximately 2 PM Employee 2, a nurse aide, answered the resident's call light, on her phone (ear buds). The aide remained on her phone having a conversation with her brother using profanity. The resident became disoriented and upset and began yelling Are you talking to me?, What is going on? Employee 2 got in Resident 2's face and said I don't need to speak to you to clean shit out of your vagina, I'm having a convo with my brother. The resident responded stop breathing on me. The aide repeatedly made comments about the resident being covered in shit while on the phone. After the incident I (Employee 1, companion) told Employee 3 (LPN supervisor), Please don't ever send that aide (Employee 2) in the room again. Employee 3 (LPN supervisor) advised me to write statement. I declined for fear of retaliation. Later that night (April 12, 2024) around 7 P.M. I asked Employee 4 (RN Supr) if Employee 3 (LPN supervisor) told him not to let Employee 1, nurse aide, care for the resident. He said no, but will pass the message on. On Saturday April 13, 2024, at approximately 10 AM I arrived at the facility. Resident 2 asked who her aide was. The resident stated that the aide was not nice and barely fed her breakfast, but what she did feed her, did it forcefully and almost made her choke. I found out the aide was the same woman from Friday (April 12, 2024, Employee 2 na). I reported the situation again to Employee 5 (RN Supr) who, at that time, removed Employee 1 from the resident's room for the remainder of the shift.</p> <p>A review of a facility investigation report dated April 12, 2024, at 2 PM revealed that on Tuesday April 16, 2024 at 11 AM, Resident 2's personal companion, Employee 1 (employed by the resident's family) called the Nursing Home Administrator to report an incident that occurred on Friday April 12, 2024. She stated that there was a tall black aide (identified as Employee 2) that entered Resident 2's room at 2 PM after she rang the call bell because the resident had a bowel movement (BM). The aide came into the resident's room, while on her cell phone with ear buds in the aide's ears, using profanity on the phone to whomever she was speaking to while caring for Resident 2. Resident 2, who is hard of hearing and blind, asked the aide if she was speaking to her (the resident). The aide responded, per Employee 1 (companion) I don't need to speak to you to clean shit out of her vagina, I'm having a convo with my brother. Employee 1 (companion) stated that the aide repeatedly made comments about the resident being covered in shit while on the cellphone.</p> <p>The facility did not obtain written or telephone statements from any staff or residents regarding this allegation of verbal abuse Employee 1 made on April 12, 2024, until April 16, 2024 after Employee 1 (companion) notified the facility's administrator. The facility failed to timely investigate and protect residents, including Resident 2 from the potential for further abuse perpetrated by Employee 2.</p> <p>According to written employee statements and interviews, Employee 1 (companion) informed nursing staff on both Friday April 12, 2024, and Saturday April 13, 2024, that Employee 2 verbally abused Resident 2. The facility did not initiate an investigation to rule out potential abuse, or mistreatment when the allegation was received by Employee 3, LPN. Employee 2 remained on duty, providing care to residents, on the resident units allowing the potential for further abuse to occur.</p> <p>During an interview on May 15, 2023, at 2 PM the DON (director of nursing) was unable to provide evidence that the facility conducted a timely and thorough investigation and protected residents from the potential for further abuse during the course of an abuse investigation.</p> <p>Refer F600</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 211.12 (c) Nursing services 28 Pa. Code 201.29 (a)(c) Resident rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 26142</p> <p>Based on review of clinical records and select facility policy and resident and staff interviews it was determined that the facility failed to provide necessary supervision and effective safety measures to prevent an elopement by one resident (Resident 1) out of 10 sampled residents</p> <p>Findings include:</p> <p>A review of a select facility policy for Leave of Absence (LOA), reviewed April 1, 2024 revealed It is the policy of the facility to coordinate, when appropriate, the preparation for nd return from a leave of absence but not limited to physical, medical and medication needs. The purpose of the policy is to ensure resident's are met during their absence from the facility and to ensure sfety of the wheelchair user and other individuals while out in the community.</p> <p>Procedures to include:</p> <ul style="list-style-type: none"> - the licensed nurse will ensure that there is a physician's order and perform any needed education. -having a personal cell phone to use during LOA is recommended -when the resident is ready to leave the facility, the nurse will initiate the LOA form, including destination, telephone number and expected time of return. <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses, which included, recent diagnosis of lung cancer, bipolar disease, tardive dyskinesia and a history of substance abuse. The resident was cognitively intact with a BIMS score of 15 (13-15 indicates cognitively intact) and independently ambulatory.</p> <p>Review of Resident 1's Elopement Risk initial assessment dated [DATE], indicated that the resident was cognitively intact, had a pertinent diagnosis (bipolar disorder), was independently mobile, did not demonstrate exit seeking behavior, and that the resident was homeless prior to admission to the facility. With respect to the question Does the resident use illicit drugs or have Substance Use Disorder asked during the assessment, no was incorrectly answered, as the resident did have a known substance use disorder as a documented diagnosis for Resident 1. The following was noted on the assessment If any question above was answered as YES, the resident has the potential to be at risk for elopement. Admitting nurse should implement interventions as appropriate until IDT(interdisciplinary team) reviews for final decision.</p> <p>A review of an initial, 3 day care plan dated May 3, 2024 revealed that Resident 1 was identified as an elopement risk, but no planned interventions were identified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Medbridge unit LOA binder (a book kept at the nurses station in which residents /family signed before leaving the facility) revealed that the sign out form included, date and time leaving the facility, anticipated time of return, signature of resident/family and the same for signing back into the facility on return from LOA. In addition to this Sign in and sign out form, the LOA form must be completed and placed into the binder. After signing out at the nurses station, the resident and/or family member are to stop at the front of the building reception desk. The receptionist then calls the resident unit nurses station to confirm the LOA and opens the front door for the resident to leave.</p> <p>A review of the current LOA sign out sheet (at the Medbridge nursing station) revealed that Resident 1 signed out May 5, 2024 at 12:45 P.M. with the estimated time of return, 1 hour. The resident signed the time back in as returning at 1:34 P.M. She signed herself out on May 7, 2024 at 1:45 P.M., with an estimated to return in one half hour, but the signature on form was illegible with the time in scratched out.</p> <p>There were no LOA forms completed for these 2 noted LOAs from the facility as noted in facility policy.</p> <p>There was no evidence at the time of the survey that nursing had obtained a physician order approving Resident 1 to go LOA as noted in facility policy.</p> <p>A review of nurses notes dated May 8, 2024 at 4:56 P.M., revealed, Resident 1 was inquiring about leaving the facility to go walk down the street to a grocery store .02 miles away. Nursing noted that a call was placed to CRNP (certified Registered Nurse Practitioner). A New order was received that resident may go LOA with family/friends but may not leave the facility property unsupervised. Resident updated of the same.</p> <p>A Nurses Note dated May 9, 2024 at 8:00 A.M. revealed that {Resident 1} requesting to go LOA this AM, unsupervised. Call placed to CRNP, gave new order, LOA order that resident may leave the facility unsupervised.</p> <p>A physician order dated May 9, 2024, (no time indicted) was noted May go LOA. This physician order did not indicate that the resident could leave the facility unsupervised.</p> <p>A review of a physical therapy skilled services note dated May 9, 2024, and signed as completed at 3:08 P. M. indicated a summary of daily skilled services to include, gait training over outside surfaces over concrete, grass, curbs with cane No loss of balance with any mobility indoors as well as outdoors.</p> <p>During an interview May 15, 2024 at approximately 2 P.M., the Director of Therapy stated that the assessment was completed on May 9, 2024. She stated that she sometimes completed her therapy documentation at home, later in the day. She could not remember what time the therapy evaluation was completed on May 9, 2024. She stated that she thought it was in the morning that day.</p> <p>A review of the Medbridge unit leave of absence sign out/in form indicated that Resident 1 signed out LOA on May 9, 2024 at 8:15 AM. She did not include the estimated time of return. The time in and return signature was not on the form. There was LOA form in the Medbridge nursing unit indicating where this resident planned to go when she left the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on May 15, 2024 at 12 PM, Resident 1 stated that she had been leaving the facility unsupervised since she was admitted , to go to the grocery store for her snacks. She stated that she did sign out and back in on the sheet in the binder, but did not fill out any other forms. She stated that the facility did not tell her about any other forms that needed to be filled out to leave. She stated that on May 9, 2024 at around 8 A.M she left the facility and at about 8:30 AM, she saw the county bus stop sign outside the grocery store and decided to get on the bus and return to her home town for a visit. She had her bus pass in her wallet. The town is approximately 8.5 miles from the facility. She stated that the social services director called her while she was on the bus and told the resident that she had to return to the facility. She stated that she just decided to get on the bus when she got to the grocery store.</p> <p>There was no documentation in the resident's clinical record concerning this incident when reviewed at the time of the survey ending May 15, 2024.</p> <p>During an interview May 15, 2024 at approximately 1 P.M., the director of social services (SW) stated that on May 9, 2024, sometime in the morning she was informed that Resident 1 had left the facility. The SW stated that she called Resident 1 on her cell phone and told her that she had to return to the facility, that she could not leave and go on a bus by herself. The SW did not relay any additional information concerning this event. She confirmed that no additional assistance was given to this resident, and that the staff just waited for her to return to the facility by herself.</p> <p>During an interview May 15, 2024 at 2 P.M., the Director of Nursing (DON) stated that on May 9, 2024, during morning IDT meeting (she could not state a time) she was informed by nursing staff that Resident 1 could not be located in the facility. The DON then called code orange indicating a resident elopement from the facility. The resident was not located and the SW called her cell phone at which time the resident informed her that she was on a bus, traveling to a nearby town.</p> <p>There was no evidence that a physician order was obtained prior to this resident leaving the facility LOA. The resident was assessed as an elopement risk at the time of admission and left the facility unaccompanied multiple times prior to her getting on public transportation without facility staff's knowledge.</p> <p>Interview with the Director of Nursing on May 15, 2024, at approximately 2:00 PM, confirmed that the facility did not implement their LOA policy and was unaware that the resident had left the facility without authorization.</p> <p>28 Pa. Code 211.10 (a)(d) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 Second Avenue Kingston, PA 18704	

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 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>26142</p> <p>Based on observation, select facility policy review and staff interview, it was determined that the facility failed to implement procedures to ensure acceptable storage and use by dates for multi-dose medications on two of four medication carts observed (B hall and C hall).</p> <p>Findings include:</p> <p>A review of facility policy titled Administering Medications last reviewed by the facility November 2023, revealed the procedure for staff to check the expiration date on the medication label. When opening a multi-dose container, place the date on the container.</p> <p>Observation of the B Hall medication cart on May 15, 2024, at 9:40 AM in the presence of Employee 1 (licensed practical nurse), revealed a vial of Lantus injectable 100 ml (a medication used to treat diabetes), a vial of Novolog injectable 100 ml (a medication used to treat diabetes), and a vial of Levemir injectable (a medication used to treat diabetes) opened and used, but not dated when initially opened.</p> <p>Observation of the C Hall medication cart on May 15, 2024, at 9:55 AM in the presence of Employee 2 (licensed practical nurse), revealed a vial of Lantus injectable opened and in use, but not dated when initially opened.</p> <p>Interview with the Nursing Home Administrator on May 15, 2024, at approximately 11:20 AM, confirmed that medications were to be dated when initially opened and put into use.</p> <p>28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>