STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395397	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Rehabilitation and Nursing Center	200 Second Avenue Kingston, PA 18704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on a review of clinical records, and resident and staff interview, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address a resident's hydration needs for one resident out of 25 reviewed (Resident 94). Findings include: A review of Resident 94's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of Multiple Sclerosis (MS-a disease in which the immune system eats away at the protective covering of the nerves resulting in disruption in the communication of the nerves between the brain and the body), diabetes, and breast cancer. An Admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated December 27, 2023, indicated that the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 15 (13-15 represents cognitively intact responses). MDS Section GG: Functional Abilities and Goals, indicated that the resident has an impairment on both sides of the upper extremities (arms) and is dependent for eating, which includes the ability to use utensils to bring food and/or liquid to the mouth. Further review of the MDS, Section V: Care Area Assessment (CAA) Summary indicated that the care area for Dehydration/Fluid Maintenance was triggered as an area of concern for the resident. The CAA worksheet indicated that Dehydration/Fluid Maintenance would be addressed in the resident's care plan. A review of Resident 94's current care plan, initially dated December 22, 2023, and revised December 29, 2023, revealed that the resident had nutritional concerns related to overweight/obesity, MS, breast cancer, diabetes mellitus, paraplegia, edema, hospice care, numerous food dislikes, allergies, skin alterations, and inability to feed self for long periods. The goal was for the resident to display no signs or symptoms of dehydration with planned interventions to monitor for signs/symptoms of dehydration, keep MD informed and obtain and monitor lab/diagnostic work as ordered. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, the resident's care plan failed to identify that the resident was dependent on staff for assistance to meet hydration needs and include specific interventions developed to provide and assist the resident with consuming adequate fluid intake to meet the resident's assessed fluid intake needs to maintain adequate hydration status and to monitor the resident's intake to prevent dehydration. During an interview with Resident 94 on March 12, 2024, at 9:50 AM, she revealed that she is completely dependent on staff for assistance with drinking and meeting her hydration needs. She stated that she is often thirsty and has resorted to asking any staff member around, a housekeeper, maintenance, and laundry personnel, to hold her cup because nursing staff does not come in frequently enough. She expressed frustration with these long wait times as she has no means to provide herself with a drink. Interview with the Director of Nursing (DON) on March 15, 2024, at approximately 11:00 AM failed to provide documented evidence the facility developed and implemented a care plan to assure that this dependent resident is provided the necessary care to meet the resident's hydration needs. Refer F807 28 Pa Code 211.12 (d)(3)(5) Nursing Services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and select facility policy and protocol, and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of practice by failing to follow physician orders for the bowel protocol prescribed for one resident (Resident 11) to promote normal bowel activity to the extent possible and failed to follow physician orders for diabetes management for one resident (Resident 8) out of 25 sampled. Findings include: According to the American Academy of Family Physicians {The American Academy of Family Physicians is one of the largest medical organizations in the US founded to promote the science and art of family medicine}the primary goal of constipation management should be symptom improvement, and the secondary goal should be the passage of soft, formed stool without straining at least three times per week). A review of the facility policy titled Bowel Protocol, last reviewed by the facility November 2023, stated the bowel protocol is as follows: 1. Bowel Protocol- Day 3-Day Shift - MOM (Milk of Magnesia) Milk of Magnesia Oral Suspension Give 30 cc by mouth as needed for 3 days no bowel movement on dayshift. Give 30 cc x 1 on 7 AM-3 PM shift for no bowel movement medium or greater in 3 days. 2. Bowel Protocol- Day 3- Evening Shift- Dulcolax Dulcolax Rectal Suppository Insert 1 suppository rectally as needed for 3 days no bowel movement on evening shift. Give one suppository per rectum x 1 on 3 PM - 11 PM shift for no bowel movement medium or greater in 3 days. 3. Bowel Protocol- Day 4 - Night Shift - Fleet Enema Fleet Enema Rectal Enema Insert 1 application rectally as needed for Day 4 no bowel movement on night shift. Give fleets enema per instruction on packet x 1 on 11 PM to 7 AM shift for no bowel movement medium or greater in 4 days. A review of the clinical record revealed that Resident 11 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues) and constipation. The resident had physician orders dated December 6, 2023, for the following bowel regimen: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Milk of Magnesia Oral Suspension (Magnesium Hydroxide). Give 30 cc by mouth as needed for 3 days no Bowel Movement Dayshift. Give 30 cc x 1 on 7-3 shift for no bowel movement medium or greater in 3 days. - Dulcolax Rectal Suppository (Bisacodyl). Insert 1 suppository rectally as needed for 3 days no bowel movement evening shift. Give one Suppository per rectum x1 on 3-11 Shift for no bowel movement medium or greater in 3 days. - Fleet Enema Rectal Enema (Sodium Phosphates). Insert 1 application rectally as needed for day 4 no Bowel Movement night shift Give Fleets Enema per instruction on packet x1 on 11-7 Shift for no bowel movement medium or greater in 4 days. Review of Resident 11's report of bowel activity from the Documentation Survey Report v2 for the month of January 2024 and the Medication Administration Record (MAR) for January 2024, revealed the that the resident did not have a bowel movement on: - January 10, 2024 - day one without a bowel movement - January 11, 2024 - day two without a bowel movement - January 12, 2024 - day three without a bowel movement, 30 cc of Milk of Magnesia was ordered for day shift but no evidence that it was administered to the resident. Dulcolax suppository was ordered for evening shift but not evidence that it was administered. - January 13, 2024 - day four without a bowel movement, Fleet enema was ordered but no evidence that it was administered. - January 14, 2024 - day five without a bowel movement, no evidence that the above ordered treatments were administered. Review of Resident 11's report of bowel activity from the Documentation Survey Report v2 for the month of February 2024 and the Medication Administration Record (MAR) for February 2024, revealed the that the resident did not have a bowel movement on: - February 2, 2024 - day one without a bowel movement - February 3, 2024 - day two without a bowel movement - February 4, 2024 - day three without a bowel movement, 30 cc of Milk of Magnesia was ordered for day shift but no evidence that it was administered to the resident. Dulcolax suppository was ordered for evening shift but no evidence that it was administered. - February 5, 2024 - day four without a bowel movement, Fleet enema was ordered but no evidence that it was administered. During an interview with the Director of Nursing (DON) on March 14, 2024, at 11:50 AM, the DON confirmed that nursing staff failed to carry out the physician ordered bowel protocol prescribed for Resident 11 to prevent constipation and promote normal bowel activity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A clinical record review revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses that include diabetes mellitus (a disease of inadequate control of blood glucose levels). A nurses note dated March 8, 2024, at 9:00 PM noted that the resident voiced a complaint that Employee 3 (LPN) took her blood sugar and never came back to give the resident, the 14 units of insulin prescribed. After speaking to the resident, the resident stated that Employee 3 (LPN) did administer the insulin but was late with its administration. Education was provided to Employee 3 (LPN) that proper insulin times needed to be followed. A physician order initially dated March 10, 2023, indicated that staff were to administer Humalog Solution 100 units/milliliter (Insulin) with instructions for the dose to be based on a sliding scale before meals and at bedtime depending on the resident's blood sugar reading; inject as per the sliding scale: if the resident's blood sugar was between 151-200, administer 2 units; if 201-250, administer 4 units; if 251-300 administer 6 units; if 301-350 administer 8 units; if 351-400, administer 10 units; if 401-999, administer 12 units. The physician was to be made aware if the resident's blood sugar reading is less than 70 or greater than 400. A physician order dated January 6, 2024, was noted for Humalog injection solution (insulin) inject 14 units subcutaneously two times per day for diabetes with hyperglycemia. Review of Resident 8's March 2024 Medication Administration Record (MAR) revealed that the Humalog injection solution 14 units two times per day was scheduled to be administered at 11:30 AM and 4:30 PM. Further review of Resident 8's March 2024 MAR revealed that on March 8, 2024, Employee 3, LPN, documented that she administered the resident's insulin as ordered by the physician, at 4:30 PM, for a blood sugar reading of 131 obtained at an hour later 5:30 PM. A review of Resident 8's Medication Administration Audit Report for March 8, 2024, confirmed that the Humalog injection solution scheduled for 4:30 PM was not administered by Employee 3 (LPN) until 8:42 PM (4 hours and 12 minutes after the scheduled time). During an interview on March 12, 2024, at approximately 1:30 PM, the Director of Nursing confirmed that Resident 8's insulin was not administered timely as per the physician order for diabetes management. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Medical records

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and staff interviews it was revealed that the facility failed to conduct timely and thorough assessments of pressure sores and initiate timely treatment to promote healing and prevent worsening of an existing pressure sore for one of 25 residents reviewed (Resident 38). Findings include: A review of the clinical record revealed that Resident 38 was readmitted to the facility on [DATE], with diagnoses that included heart failure. A review of a readmission skin assessment dated [DATE], revealed the resident had a pressure sore located on her sacrum. There was no documented assessment of the pressure sore completed upon readmission to identify the stage of the pressure sore, the size, the appearance, characteristics of the wound, to include wound bed and surrounding skin, and if any drainage or odor was present. There were no physician orders for treatment of the sacral pressure sore upon readmission on January 28, 2024. There was no documented evidence of a physician order for treatment of the pressure sore until January 30, 2024. A review of a wound summary, which was not included in the resident's clinical record, when reviewed at the time of the survey ending March 15, 2024, revealed that the resident's pressure sore was not assessed until January 31, 2024. At the time of assessment, the wound was identified as a deep tissue injury measuring 2.5 cm (centimeter) x 1.0 cm x 0.2 cm. An interview with the Director of Nursing on March 15, 2024, at approximately 1:45 PM confirmed the facility was unable to demonstrate that they had timely assessed and had implemented prompt and adequate measures to prevent the worsening of a pressure sore on the resident's sacrum upon admission to the facility. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on observation, review of clinical records and select facility incident reports, and resident and staff interviews it was determined that the facility failed to provide sufficient staff assistance, the correct assistance devices planned for the resident's use, and utilize safe technique during transfers to prevent a fall for one resident out of six sampled (Resident 8). Findings include: A review of the clinical record revealed that Resident 8 was admitted to the facility on [DATE], with diagnoses which included displacement of internal fixation device (hardware failure) of left femur (thigh bone) and congestive heart failure. A review of an Admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 5, 2024, revealed that the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status - a tool to assess cognitive function; a score of 13-15 indicates intact cognition). A review of Resident 8's care plan, initially dated January 28, 2023, indicated that the resident has a self-care performance deficit due to limited weight bearing on the left lower extremity. Planned interventions to improve the resident's current level of functioning included that the resident will be transferred with a stand-up lift (sit-to-stand lift) with the assistance of two staff and the use of a yellow sling from bed to wheelchair and the wheelchair to toilet. A nurses note dated March 11, 2024, indicated that a nurse aide was transporting the resident out of the bathroom, in the stand-up lift and the resident began to slide down, out of the lift sling. The resident was sitting on her coccyx while still in the stand-up lift. The nurse aide lowered the resident to ground and sought help. The resident was assessed for injuries and no injuries were noted and the resident had no complaints of pain. The resident stated that she cannot hold herself up for long periods on the stand-up lift. During interview with Resident 8 on March 12, 2024, at 10:40 AM the resident stated that yesterday she ended up on the floor during a transfer with the stand-up lift. The resident confirmed that thankfully she did not get hurt during the fall. Resident 8 stated that only one nurse aide was present for the transfer and that the yellow sling, which is supposed to be used, was not in her room, so the aide used a different color which was too big for the resident. Observation on March 12, 2024, at 1:20 PM in the presence of the director of nursing revealed that a yellow sling was in the bottom drawer of the resident's dresser. The resident's electronic kardex (quick reference for staff that includes summary of resident information to provide care) also noted that a yellow sling was to be used for the resident's transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an employee statement by Employee 2 (agency nurse aide) obtained on the date of the incident, dated March 11, 2024, at 10:50 AM indicated that while Employee 2 (agency nurse aide) was transferring Resident 8 from the bathroom with the sit-to-stand lift the resident started to slide down out of the sling as Employee 2 (agency nurse aide) was traveling to the bed. Employee 2 (agency nurse aide) sat the resident on her legs to keep the resident steady and lowered the resident to the floor so she could go for help. The resident did not hit her head. The yellow sling was utilized according to the nurse aide's statement. Review of an Employee Education/Counseling Form provide to Employee 2 (agency nurse aide) dated March 11, 2024, noted that employee 2 (nurse aide) was educated that two staff are required when operating any lift in the building. Review of an Occupational Therapy Evaluation dated March 12, 2024, indicated that the resident had a fall from the stand-up lift while transferring to/from the bathroom. The clinical impression noted the use of stand-up lift for transfer to bed to wheelchair to toilet with the assist of two staff using the yellow sling on the first hook/hole loop. The resident was noted to be able to transfer bed to wheelchair to toilet using the stand-up lift and yellow sling. During a telephone interview with Employee 2 (agency nurse aide) on March 13, 2024, at 10:45 AM, the employee stated at the time of the incident on March 11, 2024, Resident 8 insisted that she needed to use the bathroom. Employee 2 (agency nurse aide) confirmed that she attempted to find another staff member to help transfer the resident but that there were no other staff available. Employee 2 confirmed that she was aware that two staff were required for all transfers when utilizing a lift. Employee 2 (agency nurse aide) further stated that on the date of the incident she was not able to find the sling (yellow) in the resident's room. Employee 2 (agency nurse aide) stated that she found a red sling in the supply room where the extra slings are stored. At the time, the resident told her it was the wrong color, but the resident also insisted that she needed to go to the bathroom, so she used the red sling (despite noting in her statement that she used the yellow sling). Employee 2 (agency nurse aide) confirmed that she was transferring the resident back to the bed from the bathroom when the resident started to slide and she sat the resident on her legs, lowered the resident to the floor, and went for help. Employee 2 (agency nurse aide) confirmed that she transferred Resident 8 directly from the bed to the lift and then to the toilet in the resident's bathroom (which required pushing the resident across the room in the lift) instead of from the bed to the wheelchair to the toilet and vice versa after the resident used the toilet. Interview with the Director of Nursing (DON) on March 13, 2024, at 1:00 PM confirmed that the facility failed to provide documented evidence that the proper colored sling was utilized on the date of Resident 8's fall. The DON confirmed that two staff are to be used when any lift if used to transfer a resident. The DON also confirmed that the sit-to-stand lift is to be used to transfer Resident 8 from the bed to the wheelchair to the toilet. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records and staff interview, it was determined that the facility failed to ensure that person-centered care plans are accurately developed to meet the individualized needs of a resident receiving dialysis for one resident out of 25 sampled (Resident 11). Findings included: A review of the clinical record revealed that Resident 111 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease (kidney failure). A review of current physician's orders for Resident 111 indicated that the resident receives dialysis three times a week on Mondays, Wednesdays, and Fridays. The physician orders indicated that the resident had a right chest Tesio site (dialysis access site), and the Tesio site is to be monitored for signs and symptoms infection. Emergency care of dialysis access site was to apply pressure as needed and call 911. Review of Resident 111's current plan of care for dialysis related to renal failure and end stage renal disease initiated March 1, 2024, revealed that the care plan failed to identify that the resident had a right chest Tesio site. The care plan did not include planned interventions on how to care for the Tesio site or how to provide emergency care. Interview with the Director of Nursing on March 15, 2024, at approximately 1:45 PM confirmed that Resident 111's plan of care for dialysis did not accurately reflect the resident's current status and care needs. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and staff interview that the attending physician failed to act on pharmacist identified drug irregularities in the drug regimen of three residents out of 5 sampled (Resident 21, 102, and 112). Findings include: Review of Resident 21's clinical record revealed she was admitted to the facility on [DATE], with diagnosis to include depression, and anxiety. A review of a Consultation Report, Note to attending Physician/Prescriber, from the Pharmacist date printed November 16, 2023, revealed that the pharmacist identified that Resident 21 had an order for Trazodone 50 milligram (mg) for depression and this medication was due for assessment, if no dose reduction (GDR) is indicated, please include a brief, patient specific, rationale below. The physician response, dated November (illegible), defer to meditelecare (telehealth services). Review of Resident 102's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis to include depression, anxiety, and bipolar. A review of a Note to attending Physician/Prescriber, from the Pharmacist date printed October 19, 2023, revealed that the pharmacist identified that Resident 102 had an order for Lexapro 20 mg every day (QD) for depression. The pharmacist identified that this medication was due for assessment, if no dose reduction (GDR) is indicated, please include a brief, patient specific, rationale below. The physician responded, dated October 26, (no year), defer to psych. A review of a Note to attending Physician/Prescriber, from the Pharmacist date printed November 16, 2023, revealed that the pharmacist identified that Resident 102 had an order for Clonazepam oral tablet 0.5 mg, give 1 tablet by mouth two times a day for anxiety (GDR from three times a day (TID) May 2023. The pharmacist identified that this medication is due for assessment, if no dose reduction (GDR) is indicated, please include a brief, patient specific, rationale below. The physician did not respond to the identified irregularity, however, the Certified Registered Nurse Practitioner (CRNP) noted, dated November (illegible), defer to meditelecare. A review of a Note to attending Physician/Prescriber, from the Pharmacist date printed November 16, 2023, revealed that the pharmacist identified that Resident 102 has an order for Lamictal 150 QD for anxiety/depression (GDR May 2023). The pharmacist reported that this medication is due for assessment, if no dose reduction (GDR) is indicated, please include a brief, patient specific, rationale below. The physician response, dated November (illegible), defer to meditelecare. Review of Resident 112's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include anxiety and depression. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Consultation Report, Note to attending Physician/Prescriber, from the pharmacist dated February 8, 2024, revealed that the pharmacist identified that Resident 112 has an order for Paroxetine (antidepressant medication) 10 mg for depression. The pharmacist reported to the physician that this medication is on the Beers List (list of potentially inappropriate medication used in older adults over age 65, and is noted as a high-risk medication for utilization in the elderly due to potential for anticholinergic effects, that include dry mouth, constipation, urinary retention, increased heart rate, sedation, and orthostatic hypertension). The pharmacist requested that the physician Please review risks versus benefits for continued utilization of the medication and consider if alternative SSRI (selective serotonin reuptake inhibitor, type of antidepressant medication) would be appropriate for the resident. The physician response dated February 14, 2024, was solely noted as refer to psych. The attending physician(s) failed to document their actions in response to these reports and recommendations and the rationale for their response, agreement or disagreement with each recommendation, in the residents' medical records. Interview with the Director of Nursing (DON) on March 15, 2024, at approximately 8:25 AM confirmed there was no documentation at the time of the survey ended, that the attending physicians had acted upon these reports of drug irregularities. The attending physician and CRNP solely deferred or referred the recommendations, without documentation of the action taken or not taken to address these irregularities, which was confirmed during interview with the Nursing Home Administrator on March 15, 2024, at approximately 8:31 AM. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.2 (d)(3)(8) Medical director

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 39235 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 one of two medication storage room observed (Station A). Findings include: A review of facility policy entitled 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. Observation of Station A, medication room, on March 15, 2024, at approximately 9:00 AM, in the presence of Employee 1, Licensed Practical Nurse (LPN), revealed three (3) multi-dose bottles of Tuberculin (solution used for screening for tuberculosis) that were opened and used, but not dated when initially opened. Interview with the Director of Nursing (DON) on March 15, 2024, at approximately 10:05 AM, confirmed that medications were to be dated when opened. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (d)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395397	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Rehabilitation and Nursing Center	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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observation, review of clinical records and resident and staff interviews, it was determined that the facility failed to accommodate a resident's food preferences for one resident out of 25 reviewed (Resident 94). Findings include: A review of Resident 94's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of Multiple Sclerosis (a disease in which the immune system eats away at the protective covering of the nerves resulting in disruption in the communication of the nerves between the brain and the body) and breast cancer. An Admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated December 27, 2023, indicated that the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 15 (13-15 represents cognitively intact responses). During an interview with Resident 94 on March 12, 2024, at 9:50 AM, she stated that upon admission, dietary staff documented her food allergies/dislikes and preferences. One of the resident's dislike was fresh tomatoes. She stated that no fresh tomatoes is identified as a dislike on her meal tray ticket. She also stated that, at her request, she is served a side salad daily for lunch and dinner. She expressed frustration that the salad served to her twice a day contained fresh tomatoes. Resident 94 explained that she informed the registered dietitian (RD) and the dietary manager that she cannot eat fresh tomatoes and that even after speaking with them, the problem had not been corrected. Observation of the lunch meal on March 12, 2024, at 12:45 PM revealed that Resident 94's side salad contained fresh tomatoes. A review of the resident's meal ticket revealed the notation no fresh tomatoes. During an interview with the Registered Dietitian (RD) on March 14, 2024, at 10:10 AM, the RD confirmed Resident 94's dislikes/preferences and that no fresh tomatoes was identified and documented on her meal tray ticket. He confirmed that Resident 94's preferences and dislikes should be honored, and that the facility failed to accommodate the resident's food preferences.

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	395397	A. Building B. Wing	03/15/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 48277 Based on review of select facility policy and the minutes from Resident Council meetings and resident and staff interviews, it was determined that the facility failed to ensure fresh water was consistently readily accessible to residents to promote adequate hydration, meet residents' preference and maintain their comfort for four out of 25 residents reviewed (Residents 79, 67, 29, and 325). Findings include: A review of the facility policy titled Water at Bedside last reviewed by the facility in November 2023, indicated that the facility will provide fresh water to the residents on a daily basis during the 11 PM -7 AM shift in a 16-ounce Styrofoam cup equipped with lid and straw. The cups will be refilled on each shift of nursing duty, and as needed, with ice and water. During an interview with Resident 79 on March 12, 2024, at 10:30 AM, the resident expressed frustration that she has to consistently ask staff to provide her fresh water, and staff do not routinely provide fresh water daily. She stated you only get fresh water if you ask. Review of the minutes from a Resident Council meeting dated January 8, 2024, revealed that the residents in attendance expressed complaints with staff's failure to provide them fresh water regularly. 17 out of the 18 residents in attendance voiced this complaint, that staff on the night shift are not passing fresh water to residents. During a resident group interview on March 13, 2024, at 11:00 AM, three of five alert and oriented residents in attendance (Residents 67, 29, and 325) raised concerns that staff only provide fresh ice water on third shift (11 PM to 7 AM) and not during any other shift of nursing duty unless the residents specifically ask staff for it (fresh water). During the group interview on March 13, 2024, Resident 67 stated that he enjoys drinking fresh ice water, but he is not provided with fresh water during the day or evening unless he asks staff to provide it. During the group interview on March 13, 2024, Resident 29 stated that she is not provided with fresh ice water during any shift and that she has to ask for fresh ice water every day. During the group interview on March 13, 2024, Resident 325 stated that the third shift (11 PM to 7 AM) pass water around 11 PM but that during the day, refills of fresh ice water are not provided during the other shifts. Interview with the Nursing Home Administrator (NHA) on March 15, 2024, at approximately 2:00 PM stated that it is his understanding and expectation that the water pass is to be conducted once per shift and as needed. The NHA confirmed the facility failed to demonstrate that fresh ice water was readily accessible as preferred by residents to promote adequate and hydration and comfort for residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (d)(3)(5) Nursing services. 28 Pa. Code 211.10 (a)(d) Resident care policies