

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  08/23/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</b></p> <p>Based on a review of clinical records and resident and staff interview, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by seven residents out of the 29 residents sampled (Residents 3, 34, 85, 66, 57, 6, and 38).</p> <p>Findings include:</p> <p>A clinical record review revealed that Resident 3 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 5, 2024 revealed that Resident 3 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed Resident 34 was admitted to the facility on [DATE]. A review of a MDS assessment dated [DATE], revealed that Resident 34 is cognitively intact with a BIMS score of 13 (a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed Resident 85 was admitted to the facility on [DATE]. A review of a MDS assessment dated [DATE], revealed that Resident 85 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed Resident 66 was admitted to the facility on [DATE]. A review of a MDS assessment dated [DATE], revealed that Resident 66 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed Resident 57 was admitted to the facility on [DATE]. A review of a MDS assessment dated [DATE], revealed that Resident 57 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed Resident 6 was admitted to the facility on [DATE]. A review of a MDS assessment dated [DATE], revealed that Resident 6 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on August 20, 2024, at 10:45 AM, Resident 85, expressed that she is frustrated and embarrassed because she often waits an hour or longer for staff to provide her incontinence care. She indicated she uses her cell phone to call the facility administration when staff fails to respond to her call bell. Resident 85 explained that sometimes when she soils herself, it leaks out onto her bedsheet, and staff will sometimes put her back to bed and not change her linens.</p> <p>During an interview on August 20, 2024, at 11:00 AM, Resident 66 indicated last night she waited two and a half hours for staff to provide care. She explained she rang her call bell to be changed and waited for hours in her soiled brief. Resident 66 indicated she was not able to go to sleep until after 1:00 AM. She expressed feeling frustrated about her care at the facility because she usually waits over an hour for staff to respond to her call bell for assistance.</p> <p>During an interview on August 20, 2024, at 12:15 PM, Resident 3 indicated she experiences long wait times for care. She explained that she has recently waited two hours to be changed after she soiled her brief. Resident 3 indicated that it usually takes at least 30 minutes before someone provides her care after she rings her call bell for assistance.</p> <p>During an interview on August 20, 2024, at 12:40 PM, Resident 57 indicated that he is upset with the lack of care he experiences at the facility. He explained that he is in the process of transferring to another facility. Resident 57 expressed that he wants to stay but is frustrated with the long wait times for assistance. He indicated this morning he waited three hours for staff to bring him a cup of water. Resident 57 explained when his regular staff are off, he waits 30 minutes or longer for care.</p> <p>During an interview on August 20, 2024, at 12:50 PM, Resident 34 indicated that she rings her call bell for assistance, but no one answers. She explained she needs assistance to get to her to the bathroom. Resident 34 indicated she sometimes waits over an hour for help and has started transferring herself to her toilet. She explained that she knows it is not safe, but she can't hold it and does not want to soil herself. Resident 34 expressed she is frustrated because she is not getting the care she needs.</p> <p>During an interview on August 21, 2024, at 10:30 AM, Resident 6 indicated he sometimes waits over 30 minutes for staff to respond after ringing his call bell for assistance. He explained in the past week he waited over two and a half hours for staff to assist him to the bathroom. Resident 6 indicated if his regular nurse aide is not working, he does not receive his scheduled shower. He explained that agency staff will not help, and it results in long wait times for care and missed showers for residents.</p> <p>During interview with Resident 38, a cognitively intact resident, on August 20, 2024, at 10:00 AM the resident stated he often waits over an hour on the 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM shift for staff to answer the call bell.</p> <p>During an interview on August 23, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) verified all residents at the facility should be treated with dignity and respect and provided care in a manner that promotes each resident's quality of life. The NHA was unable to explain why residents are reporting untimely staff responses to residents' requests for assistance or why residents are reporting they are not receiving regular showers.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>48277</p> <p>Based on observation, review of select facility policy, clinical record review, and resident and staff interviews, it was determined the facility failed to provide housekeeping services to maintain a clean and safe resident environment in two resident rooms and the A unit. (Resident 68 and Resident 39)</p> <p>Findings include:</p> <p>Review of facility policy titled Shower/Bath last reviewed by the facility on July 18, 2024, indicated that staff will change a resident's bed linens on shower days or when visible soilage is observed.</p> <p>An observation on August 20, 2024, at 11:44 AM , in resident room A06, bed A, revealed soiled bed linens on Resident 68's bed. The resident's pillowcase contained multiple reddish-brown stains, the fitted sheet had a large yellow stain in the middle of the mattress, and there were multiple light brown stains at the foot of the bed.</p> <p>Interview with Resident 68, a cognitively intact resident with a BIMS score of 15 (BIMS-brief interview to assess cognitive status. A score of 13-15 indicates intact cognitive responses), indicated he has not had his sheets changed in a couple of weeks. He stated his shower days are Mondays and Thursdays and he received a shower yesterday (Monday), but that staff did not change his sheets.</p> <p>Further observation of resident room A06, bed B, revealed multiple light brown stains of various sizes on Resident 39's fitted sheet.</p> <p>Interview with Resident 39, a cognitively intact resident with a BIMS score of 15, stated that he takes a shower every Monday and Friday. He further stated his bed lines haven't been changed in a while, can't you tell? He also stated the shower room is often dirty and that yesterday the shower chair had a piece of sh*t on it.</p> <p>Review of Resident 68's August 2024 Documentation Survey Report indicated he was scheduled to receive a shower on Mondays and Thursdays during the day shift. The report also indicated that Resident 68 received a shower on August 19, 2024, the day before the surveyor's observation and interview.</p> <p>Review of Resident 39's April 2023 Documentation Survey Report indicated that she was scheduled to receive a shower on Mondays and Fridays during the evening shift. The report also indicated that Resident 39 received a shower on August 19, 2024, the day before the surveyor's observation and interview.</p> <p>Observation conducted of the A Hall shower room on August 20, 2024, at 2:32 PM revealed brown stains on the seat of a shower chair and a brown pebble-shaped substance on the left outer surface of the shower chair seat.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A second observation of the above areas in Room A06 on August 21, 2024, at 2:00 PM, revealed the above findings remained as initially observed and in the same condition as previously observed during the initial observation conducted on August 20, 2024.</p> <p>Interview with the Infection Preventionist on August 23, 2024, at approximately 11:25 AM confirmed it is the facility's policy that bed lines are changed upon soilage and on the residents' shower days. He also confirmed Resident 68 and 39's bed linens should have been changed on their scheduled shower day, and the facility is to be maintained daily to provide a clean and sanitary environment for the residents.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21738</p> <p>Based on review of the facility's abuse policy, clinical records, facility investigations, information submitted by the facility to the state agency, and staff interview it was determined the facility failed to timely report an alleged violation of misappropriation of resident property for one resident out of 26 reviewed (Resident 42).</p> <p>Findings include:</p> <p>Review of the facility's Abuse Policy reviewed by the facility July 18, 2024, indicated the resident has the right to be free from abuse, neglect, misappropriation of resident property (deliberate misplacement, exploitation, or wrongful temporary, or permanent use of a resident's belongings or money without the resident's consent) and exploitation. It is the policy of the facility that abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility.</p> <p>Review of the clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses of end stage renal disease with hemodialysis (a treatment that filters waste, salts, and fluids from the blood when the kidneys are no longer able to do so) and a right femur (thigh bone) fracture.</p> <p>An admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 4, 2024, indicated the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13 to 15 indicates cognitively intact).</p> <p>Review of a nurses note dated August 10, 2024, at 10:21 PM revealed at approximately 4:30 PM the resident refused medication, stated she won't take it because she hasn't and won't be eating. The resident was on her cellphone at the time, requesting the direct phone number to the local police. Resident was very distraught and tearful, stating someone took her seventy dollars worth of snacks at her bedside along with her phone charger. The registered nurse supervisor was informed of the situation. The registered nurse supervisor went to the resident's room to assess and remedy the situation. The resident was thankful for the help and cooperative to care for remainder of the shift.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility report to the State Survey Agency revealed the incident, which occurred on August 9, 2024, and documented in the clinical record August 10, 2024, was not reported to the State Agency, Area Agency on Aging, and the police until August 13, 2024. The facility's investigation which concluded on August 13, 2024, was unable to identify a perpetrator.</p> <p>An interview with the administrator on August 23, 2024, at approximately 10:00 AM failed to provide documented evidence the facility timely implemented the facility Abuse Policy for reporting to appropriate agencies including the state agency, the local area agency on aging, and law enforcement in response to the resident's allegation of potential misappropriation of resident property on August 9, 2024.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 201.14(a)(c) Responsibility of Licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a)(c) Resident rights</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48276</p> <p>Based on observation, clinical record review, and staff interview, it was determined the facility failed to develop and implement a person-centered care plan to meet the specific needs of two residents out of 29 sampled (Residents 63 and 87).</p> <p>Findings including:</p> <p>A clinical record review revealed Resident 63 was admitted to the facility on [DATE], with diagnoses that include hemiplegia (paralysis on one side of the body) and cerebral infarction (brain damage that results from a lack of blood).</p> <p>A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 4, 2024, revealed that Resident 63 is severely cognitively impaired with a BIMS score of 03 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01-07 indicates severe cognitive impairment).</p> <p>A care plan indicated Resident 63 is at risk for falls related to his diagnoses of hemiplegia initiated on June 28, 2024. Interventions in place to mitigate Resident 63's risk for falling include bilateral floor mats and a scoop mattress (a type of mattress with edges built higher than the center to mitigate rolling out of bed).</p> <p>An Admission Nursing Evaluation Fall Risk assessment dated [DATE], revealed Resident 63 is a high risk for falling. The assessment indicates Resident 63's fall risk care plan needs to include bilateral floor mats.</p> <p>An observation on August 21, 2024, at 1:40 PM revealed Resident 63 was in his room, lying in bed. Bilateral floor mats and a scoop mattress were not observed as planned.</p> <p>During an interview and observation on August 22, 2024, at 11:00 PM, Employee 6, Licensed Practical Nurse, confirmed that Resident 63 was in his room lying in bed. Employee 6, LPN, confirmed the resident did not have a scoop mattress and there were not bilateral floor mats in the room.</p> <p>During an interview on August 23, 2024, at approximately 10:30 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure that person-centered care plans are implemented to mitigate residents' risk of falling.</p> <p>A review of the clinical records revealed that Resident 87 was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and fracture of the neck of the left femur (hip fracture).</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician's order dated June 17, 2024, revealed an order for ace wraps to his bilateral legs, on in the AM and off at HS (hours of sleep). Check skin integrity with application and removal two [NAME] a day.</p> <p>A nurses note date June 25, 2024, at 1:08 PM indicated the resident had increased edema in the lower extremities. The CRNP (certified registered nurse practitioner) is aware and will be in to see resident.</p> <p>A review of the physician progress note dated July 5, 2024, indicated the chief complaint/nature of presenting problem was lower extremity edema, hypokalemia (low potassium), and congestive heart failure.</p> <p>Review of Resident 87's current comprehensive care plan in effect at the time of the survey ending August 23, 2024, revealed no evidence the facility had addressed the resident's specific needs related to his lower extremity edema and it did not any therapeutic measures, such as ace wraps, that were to be applied to his legs.</p> <p>During an interview with the Nursing Home Administrator on August 23, 2024 at approximately 11:00 AM, he confirmed that the resident's edema and measures to treat the edema were not addressed on the resident's plan of care.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to ensure that dependent residents were provided with the necessary services to maintain good personal hygiene, by failing to provide showers/bed bath as scheduled and personal grooming for two of 26 residents sampled (Residents 42 and 138).</p> <p>Findings include:</p> <p>Review of the clinical record revealed that Resident 42 was admitted to the facility on [DATE], with diagnoses to end stage renal disease with hemodialysis (a treatment that filters waste, salts, and fluids from the blood when the kidneys are no longer able to do so) and a right femur (thigh bone) fracture.</p> <p>An admission Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 4, 2024, indicated the resident was cognitively intact with a BIMS score of 15 (brief interview for mental status, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 13 to 15 indicates cognitively intact) and was dependent on staff for bathing.</p> <p>A review of Resident 42's August 1, 2024 through August 22, 2024, Task Documentation Report revealed the resident was to be showered twice weekly on Tuesday and Saturday on the 3:00 PM to 11:00 PM shift.</p> <p>Further review of the Task Documentation Report revealed the resident received a bed bath on August 3, August 13, and August 20, 2024. The resident's scheduled shower/bed bath was not provided on August 6, August 10, or August 17, 2024. The resident did not receive two bed baths per week as scheduled.</p> <p>Interview with Resident 42 on August 20, 2024, at approximately 11:00 AM confirmed she did prefer a bed bath instead of a shower. Resident 42 confirmed that her preference was for two bed baths per week.</p> <p>A review of clinical record revealed that Resident 138 was admitted on [DATE], with diagnoses which included Type 2 diabetes, heart attack, acute kidney failure with dependence on dialysis, and acute respiratory failure with hypoxia (low levels of oxygen in your body tissue) and required extensive assistance from staff with activities of daily living.</p> <p>An observation of Resident 138 on August 21, 2024, at approximately 11:00 AM. observed the resident in bed, with grossly long and dirty fingernails on both hands and his lips were dry with numerous areas of peeling skin. During observation, the resident was attempting to peel the skin from his lips with his long dirty fingernails.</p> <p>During an interview with Resident 138 at time of observation, the resident stated that he needs help to perform oral and nail care. Resident 138 further stated that he isn't always accepting of staff assistance but could not provide a reason for not letting staff assist him with his hygiene needs.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on a review of clinical records and resident and staff interview, it was determined the facility failed to provide person-centered quality care by failing to follow physician orders for NPO (nothing by mouth) in preparation for an abdominal ultrasound for one resident (Resident 133) and failed to follow physician orders for the consistent application of a prescribed therapeutic measure, ace wraps, for one resident of 29 sampled (Resident 87).</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 133 was admitted to the facility on [DATE], with diagnoses to include hepatic encephalopathy (loss of brain function when a damaged liver does not remove toxins from the blood), dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and gastro-esophageal reflux disease (stomach acid or bile irritates the food pipe lining).</p> <p>A review of a physician's order dated August 20, 2024, ordered the resident to have an ultrasound of the abdomen for a diagnosis of abdominal pain.</p> <p>A physician's order dated August 20, 2024, at 2:53 PM, indicated the resident was to be NPO after midnight (August 20, 2024 into August 21, 2024) until the ultrasound of the abdomen was obtained.</p> <p>A nurses note dated August 21, 2024, at 11:42 AM noted the facility was unable to complete the ultrasound this AM. The ultrasound was rescheduled for Friday morning. The physician and responsible party aware.</p> <p>Interview with Employee 7 (licensed practical nurse) on August 21, 2024, at 12:00 PM indicated that Resident 133's ultrasound was cancelled because the resident ate breakfast.</p> <p>Interview with Employee 1(nurse aide) on August 21, 2024, at 12:37 PM revealed that while she was picking up breakfast trays around 10:00 AM, she noticed that Resident 133 did not have a breakfast tray. She asked Resident 133 if he wanted something to eat at which he replied yes. Employee 1 went to the kitchen to get him a tray which consisted of an egg on an English muffin. Employee 1 indicated that she was unaware that he was having a test and was not informed he was NPO.</p> <p>Interview with the Corporate Registered Nurse on August 21, 2024, at 1:20 PM stated that during rounds for each change of shift, nursing staff are to communicate with each other if any residents in their care have had any change of condition, any scheduled tests, or require any restrictions, such as NPO status. She confirmed that staff failed to communicate Resident 133's NPO status with the nurse aide which resulted in the resident eating and the ultrasound being cancelled and that the facility failed to follow the physician's order for the resident to be NPO prior to the scheduled abdominal ultrasound.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Kingston Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Second Avenue Kingston, PA 18704	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the clinical records revealed that Resident 87 was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and fracture of the neck of the left femur (hip fracture).</p> <p>A physician's order dated June 17, 2024, revealed an order for ace wraps to his bilateral legs, on in the AM and off at HS (hours of sleep). Two times a day and check skin integrity with application and removal.</p> <p>Observation of Resident 87 sitting in his Broda chair (specialty chair used for positioning and pressure reducing) in the B Hall dining room on August 20, 2024, revealed the resident was not wearing ace wraps on his bilateral lower extremities (legs) as ordered.</p> <p>Additional observation of Resident 87 sitting in his Broda chair in the large dining room on August 21, 2024, at 10:00 AM, revealed the resident was not wearing ace wraps on his bilateral lower extremities as ordered at the time of the observation.</p> <p>Interview with Employee 2 (registered nurse), on August 21, 2024, at 10:00 AM confirmed the resident had an active physician's orders for ace wraps to his bilateral lower extremities. Employee 2 confirmed Resident 87 was not wearing ace wraps at the time observed.</p> <p>An additional observation of Resident 87 sitting in this Broda chair in the hallway on August 22, 2024, at 10:40 AM revealed the resident was not wearing ace wraps on his bilateral lower extremities as ordered at the time of the observation.</p> <p>Interview with Employee 3 (registered nurse) on August 22, 2024, at 10:40 AM confirmed that the resident was not wearing ace wraps as ordered. Employee 3 also confirmed there were no ace wraps present in the resident's room or nurse's treatment cart for the resident to use.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>21738</p> <p>Based on a review of clinical records, select facility policy, and staff interview it was determined the facility failed to ensure that physician ordered intravenous (IV- medication is administered through needle or tube inserted into a vein) medications, an antibiotic, were administered as prescribed for one resident out of 26 sampled (Resident 67).</p> <p>Findings include:</p> <p>Review of the facility Medication Administration Policy last reviewed by the facility on July 18, 2024, indicated medications shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with orders, including any required time frame.</p> <p>Review of Resident 67 clinical record revealed the resident was readmitted to the facility from the hospital on July 30, 2024, with a PICC line (peripherally inserted central catheter- thin flexible tube inserted into a vein in the upper arm and guided into a large vein above the right side of the heart and used to administer fluid and medications) and diagnoses to include osteomyelitis (bone infection that causes inflammation and swelling).</p> <p>An admission physician order dated July 31, 2024, was noted for Daptomycin (an antibiotic used to treat bacterial infections) 650 MG intravenously daily for osteomyelitis, surgical wound infection with an end date of August 27, 2024.</p> <p>Review of Resident 67's August 2024 Medication Administration Record revealed that the Daptomycin was not administered as ordered on August 12, 2024, at 6:00 AM.</p> <p>An admission physician order dated July 31, 2024, was noted for Cefepime (an antibiotic used to treat bacterial infections) 2 grams intravenously every eight hours daily for osteomyelitis, surgical wound infection.</p> <p>Review of Resident 67's August 2024 Medication Administration Record revealed that the Cefepime was not administered on August 3, 2024, at 7:00 PM and August 15, 2024, at 12:00 PM.</p> <p>Interview with the regional nurse consultant on August 23, 2024, at approximately 9:30 AM confirmed the facility failed to administer three doses of the IV antibiotic therapy prescribed for Resident 67 and failed to notify the attending physician of the missed doses.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident care policies</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on review of clinical records, select facility policy, observation, and staff interview, it was determined the facility failed to maintain oxygen equipment in a functional and sanitary manner for three residents out of 29 sampled (Residents 9, 22, and 135).</p> <p>Findings include:</p> <p>Review of facility policy titled Oxygen Administration last reviewed by the facility on July 18, 2024, revealed when oxygen is not in use, the oxygen tubing, nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen) or mask is to be stored separately in a labeled plastic bag.</p> <p>Review of Resident 9's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD- lung disease that blocks airflow and makes it difficult to breathe), and atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls which causes obstruction of blood flow).</p> <p>The resident had a physician's order dated July 19, 2024, for Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML [medication inhaled into the lungs using a nebulizer machine (a small machine that turns liquid medicine into a mist that can be inhaled into the lungs)] - 3 ml inhale orally via nebulizer every six hours for congestion for 5 days. The physician's order end date for the nebulizer treatment was July 24, 2024.</p> <p>An observation conducted on August 20, 2024, at 1:15 PM revealed Resident 9 was awake and lying in bed. The resident's nebulizer machine, including the tubing and mask, were placed on the overbed table. Also present on the overbed table were opened beverages. The nebulizer mask was uncovered and not bagged.</p> <p>Review of Resident 22's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include heart failure (a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and cerebral infarction (brain damage that results from a lack of blood).</p> <p>The resident had a current physician's order, dated July 27, 2024, for Albuterol Sulfate Nebulization Solution (2.5MG/3ML) 0.083. One vial inhale orally via nebulizer every 6 hours as needed for SOB (shortness of breath).</p> <p>An observation conducted on August 20, 2024, at 1:20 PM revealed Resident 22 was sitting in her wheelchair next to her bed. The resident's nebulizer machine, including the tubing and mask, were placed on the bedside nightstand. Also present on the nightstand were an opened canister of hair spray, a bottle of lotion and opened snack bags. The nebulizer mask was left uncovered and not bagged. There was a labeled plastic bag tied to Resident 22's nebulizer tubing. The name and room number written on the plastic bag tied to the resident's nebulizer tubing was not the name or room number of Resident 22.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 135's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include asthma (airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), chronic pulmonary edema (fluid accumulation in the lungs, making it difficult to breathe normally), and obstructive sleep apnea (intermittent airflow blockage during sleep).</p> <p>The resident had a current physician's order, dated July 15, 2024, for BiPAP (Bilevel Positive Airway Pressure-a mechanical breathing device with a mask that delivers air pressure to ensure breathing airways stay open during sleep) due to obstructive sleep apnea. Apply at hours of sleep and remove in the AM.</p> <p>An observation conducted on August 20, 2024, at 10:47 AM revealed Resident 135 was sitting in her wheelchair next to her bed. The resident's BiPAP machine, including the tubing and the fabric mask, were placed on the bedside nightstand. Also present on the nightstand were open beverage containers, opened snack packages and toiletries. The BiPAP mask was left uncovered and not bagged.</p> <p>An additional observation made on August 21, 2024, at 8:18 AM revealed the BiPAP tubing, and fabric mask were laying on the floor next to her bed. Also on the floor, in direct contact the mask, was a used latex glove. The mask and tubing were not bagged.</p> <p>Interview with the Infection Preventionist on August 23, 2024, at approximately 11:20 AM confirmed that residents' respiratory equipment and supplies should be bagged when not in use to prevent contamination.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.10 (a)(c)(d) Resident Care Policies</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on observation, select facility policy review and staff interview, it was determined the facility failed to implement procedures to ensure acceptable storage for medications on one of two nursing units observed. (Medication Storage Room B).</p> <p>Findings include:</p> <p>A review of facility policy titled Disposition of Discontinued Medications, last reviewed by the facility on July 18, 2024, revealed the facility will destroy or return medication in accordance with the facility policy. The discontinued medication procedure includes four steps:</p> <ol style="list-style-type: none"> <li>1. Obtain order for discontinued medications</li> <li>2. Timely remove medication from medication cart</li> <li>3. Follow pharmacy/facility policy specific to a. controlled substances b. fentanyl patches c. medication returns</li> <li>4. Medication awaiting final disposition will be locked in the medication room once removed from the medication cart.</li> </ol> <p>A review of facility policy titled 3.0 Returned Medications to the Pharmacy &amp; Credits last reviewed by the facility on July 18, 2024, revealed the procedure of returning medication from the facility to the pharmacy indicated, if allowed, medications are to be promptly returned to the pharmacy for credit after medications have been discontinued.</p> <p>Observation of the medication storage room B on August 22, 2024, at 9:25 AM, in the presence of Employee 5 (licensed practical nurse), revealed two (2) mauve wash basins and one cardboard box on the counter. One basin contained 33 medication cards, another 27, and the cardboard box contained 29 medications cards that needed to be destroyed or returned to the pharmacy.</p> <p>Interview with Employee 5 indicated it is the responsibility of the medication nurse to remove any medications from their cart that are no longer in use due to resident discharge, death, or discontinuation and place them in the bin in the medication room. It is also the responsibility of the medication nurse to complete disposition of medication paperwork when the medication is removed from the cart to inventory the medications, complete disposition paperwork, and destroy or return the medications to pharmacy.</p> <p>Observation of one of the mauve basins revealed that medications prescribed for Resident CR4, who was discharged on [DATE], remained in the medication room, awaiting return to the pharmacy. There was no evidence a medication disposition form had been completed until inquiry of the surveyor on August 22, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Infection Preventionist on August 23, 2024, at approximately 11:20 AM confirmed the disposition of medications and pharmacy return of medication was not completed timely for discontinued/discharged medications.</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>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48277</p> <p>Based on review of clinical records and staff interview, it was determined the facility failed to maintain complete and accurate records of treatment administration to one resident of 29 sampled (Resident 87).</p> <p>Findings included:</p> <p>A review of the clinical records revealed Resident 87 was admitted to the facility on [DATE], with diagnoses to include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and fracture of the neck of the left femur (hip fracture).</p> <p>A physician's order dated June 17, 2024, revealed an order for ace wraps to his bilateral legs, on in the AM and off at HS (hours of sleep). Two times a day check skin integrity with application and removal.</p> <p>Observation of Resident 87 sitting in his Broda chair (specialty chair used for positioning and pressure reducing) in the B Hall dining room on August 20, 2024, revealed that the resident was not wearing ace wraps on his bilateral lower extremities (legs) as ordered.</p> <p>However, a review of Resident 87's Treatment Administration Record (TAR) for August 20, 2024, indicated he had had received the ace wraps to his bilateral extremities with the application time of 6:00 AM.</p> <p>Additional observation of Resident 87 sitting in his Broda chair in the large dining room on August 21, 2024, at 10:00 AM revealed that the resident was not wearing ace wraps on his bilateral lower extremities as ordered at the time of the observation.</p> <p>Interview with Employee 2 (registered nurse), on August 21, 2024, at 10:00 AM confirmed that the resident had an active physician's orders for ace wraps to his bilateral lower extremities. Employee 2 confirmed Resident 87 was not wearing ace wraps at the time observed.</p> <p>However, a review of Resident 87's Treatment Administration Record (TAR) for August 21, 2024, indicated he had had received the ace wraps to his bilateral extremities with the application time of 6:00 AM.</p> <p>An additional observation of Resident 87 sitting in this Broda chair in the hallway on August 22, 2024, at 10:40 AM revealed that the resident was not wearing ace wraps on his bilateral lower extremities as ordered at the time of the observation.</p> <p>Interview with Employee 3 (registered nurse) on August 22, 2024, at 10:40 AM confirmed that the resident was not wearing ace wraps as ordered. Employee 3 also confirmed that there were no ace wraps present in the resident's room or nurse's treatment cart for the resident to use.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>However, a review of Resident 87's Treatment Administration Record (TAR) for August 22, 2024, indicated he had had received the ace wraps to his bilateral extremities with the application time of 6:00 AM.</p> <p>Interview with the Nursing Home Administrator on August 23, 2024, at approximately 11:00 AM failed to explain why nursing staff had documented the resident received the above treatment on the morning of August 20, 21, and 22, 2024, when staff had not administered the treatment as scheduled.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 211.5(f) Medical records</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</b></p> <p>Based on observation, a review of clinical records, CDC infection control guidance, and staff interview it was determined the facility failed to implement transmission-based precaution control practices to mitigate the risk of COVID-19 infections in the facility for four out of five residents sampled for transmission-based precautions (Residents 2, 63, 66, and 121) and failed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one out of 29 residents sampled (Resident 49).</p> <p>Findings include:</p> <p>A review of The Centers for Disease Control and Prevention 2007 Guideline for Isolation Precautions: Preventing Transmission of Infection Agents in Healthcare Settings, last updated July 2023, Section II.E. Personal Protective Equipment (PPE) for Healthcare Personnel, revealed that designated containers for used disposable or reusable PPE should be placed in a location that is convenient to the site of removal to facilitate disposal and containment of contaminated materials. Furthermore, the guidance indicates PPE should be removed at the doorway before leaving a patient room.</p> <p>A clinical record review revealed Resident 2 was admitted to the facility on [DATE]. A progress note dated August 17, 2024, at 11:11 PM revealed the resident tested positive for SARS-CoV-2 (COVID-19). A physician's order for Resident 2 to be placed on droplet isolation precautions for COVID-19 was initiated on August 17, 2024.</p> <p>An observation on August 23, 2024, at 11:15 AM revealed Resident 2's room C-4 was not furnished with a designated container for the disposal of PPE gear at the point of exit. Residents' personal waste bins were the only observed trash containers.</p> <p>A clinical record review revealed Resident 121 was admitted to the facility on [DATE]. A progress note dated August 21, 2024, at 12:39 PM indicated the resident is COVID-19 positive. A physician's order for Resident 121 to be placed on droplet isolation precautions for COVID-19 was initiated on August 21, 2024.</p> <p>An observation on August 23, 2024, at 11:17 AM revealed Resident 121's room C-11 was not furnished with a designated container for the disposal of PPE gear at the point of exit. Residents' personal waste bins were the only observed trash containers.</p> <p>A clinical record review revealed Resident 66 was admitted to the facility on [DATE]. A progress note dated August 19, 2024, at 5:20 PM indicated the resident is COVID-19 positive.</p> <p>A review of physician's orders revealed no documented evidence that isolation precautions were ordered for Resident 66.</p> <p>An observation on August 23, 2024, at 11:20 AM revealed Resident 66's room B-15 was identified with signage indicating droplet transmission-based precautions were in effect. The room was not furnished with a designated container for the disposal of PPE gear at the point of exit. Residents' personal waste bins were the only observed trash containers.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A clinical record review revealed Resident 63 was admitted to the facility on [DATE]. A progress note dated August 21, 2024, at 2:18 PM indicated the resident is COVID-19 positive.</p> <p>A physician's order for Resident 63 to be placed on droplet/airborne isolation precautions was initiated on August 21, 2024.</p> <p>An observation on August 23, 2024, at 11:25 PM revealed Resident 63's room B-5 was not furnished with a designated container for the disposal of PPE gear at the point of exit. Residents' personal waste bins were the only observed trash containers.</p> <p>An observation of the B Station Nursing Unit Resident Pantry on August 23, 2024, at 10:40 AM revealed that Resident 121's partially eaten breakfast tray was on the counter next to the sink. There was a used N-95 mask and used gloves on the tray.</p> <p>During an interview on August 23, 2024, at approximately 12:00 PM, the infection Preventionist confirmed that the facility failed to furnish resident rooms B-5, B-11, C-4, and C-11 with a designated container for the disposal of PPE equipment. The infection Preventionist indicated the resident's personal trash bins were utilized when staff were disposing of used PPE equipment. The infection Preventionist further confirmed that meal trays were to be promptly returned to the kitchen after being removed from resident rooms and that PPE should be properly disposed of and not to be placed on meal trays.</p> <p>Clinical record review revealed Resident 49 was admitted to the facility on [DATE], with diagnoses to include stage 4 pressure ulcer of the sacral region, and chronic pain syndrome.</p> <p>Review of facility documentation Report of Consultation dated October 20, 2023, revealed Resident 49 underwent a procedure for a suprapubic catheter placement (a thin, flexible tube inserted into the bladder via a small incision in the lower abdomen to collect and drain urine).</p> <p>Review of a physician's order dated October 23, 2023 revealed an order to flush SPT (suprapubic tube) with 45 mls of Acetic acid 0.25% Q shift (every shift) for patency (being open or unobstructed).</p> <p>Observation on August 20, 2024, at 11:42 AM, revealed an undated, unlabeled piston syringe inside a plastic bottle with 7 fluid ounces of a clear liquid remaining in the bottle, and an undated, unlabeled, opened 500 mL bottle of Acetic Acid with 50 mls remaining in the bottle. The piston syringe/bottle and bottle of Acetic Acid was placed on top of the bedside nightstand. Also on the bedside nightstand was a Styrofoam cup containing an unknown liquid, a bag of Lays chips, an opened bottle of antiseptic skin cleanser, an opened jar of zinc oxide, a spray bottle of wound cleanser, a reacher, a bottle of shampoo, a bottle of lotion, and a gray basin filled with toiletries and bandages.</p> <p>Interview with Employee 4 (licensed practical nurse), on August 21, 2024, at 9:20 AM confirmed the observations and further confirmed there was no evidence of how old the items were, the items should have been labeled and dated, and the items were not in a manner to prevent the potential spread of infection.</p> <p>During an interview with the Infection Preventionist on August 22, 2024, at approximately 1:30 PM, he confirmed the facility failed to maintain resident care equipment in a manner to prevent the potential spread of infection.</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  08/23/2024
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 0880  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	28 Pa. Code 211.10(a)(c)(d) Resident care policies  28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services  28 Pa. Code 201.14(a) Responsibility of licensee.  28 Pa. Code 201.18(b)(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  08/23/2024
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 0914</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide bedrooms that don't allow residents to see each other when privacy is needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</b></p> <p>Based on a review of clinical records, observations, and resident and staff interviews, it was determined the facility failed to ensure each resident room is designed and equipped to assure full visual privacy for one out of the 29 residents sampled (Resident 107).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 107 was admitted to the facility on [DATE], with diagnoses that include acute kidney failure (a sudden loss of kidney function) and intellectual disabilities (significant deficits in general cognitive abilities such as reasoning, planning, and problem solving).</p> <p>A review of an admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 22, 2024, revealed that Resident 107 is cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status- a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact).</p> <p>An observation on August 20, 2024, at 10:20 AM in room A-11 revealed that Resident 107's bed lacked ceiling privacy curtains. Room A-11 is a triple-occupancy room, and Resident 107 had two roommates at the time. The two other beds in resident room A-11 were equipped with privacy curtains.</p> <p>During an interview at the same time as the observation, Resident 107 indicated there were no ceiling privacy curtains around her bed since she moved into the room about a week ago.</p> <p>During an interview on August 21, 2024, at approximately 1:00 PM, the Nursing Home Administrator (NHA) confirmed that each resident room should be designed and equipped to assure privacy.</p> <p>28 Pa Code 201.18 (e)(2.1) Management</p>		