

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395905	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER Third Avenue Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 702 Third Avenue Kingston, PA 18704	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41460</p> <p>Based on observation, clinical record review and staff interview, it was determined that the facility failed to maintain an environment free of potential accident hazards to the extent possible on one of three resident hallways (Rooms 9-16).</p> <p>Findings include:</p> <p>Observations made during an environmental tour of the facility on April 16, 2024, at approximately 11 AM revealed an unattended, and unlocked, treatment cart in the hallway of the resident unit.</p> <p>Further observation of the treatment cart revealed that the second drawer was open, exposing the contents of prescription creams and/or ointments. The sixth drawer was also open and exposed treatment supplies used to perform treatments to residents.</p> <p>Observation of the top of the cart revealed a laptop, and packages of unopened cures (tool with a sharp blade to remove nonviable skin).</p> <p>Observation further revealed residents were ambulating and self-propelling in wheelchairs in the hallway while the opened cart was left unattended.</p> <p>Interview with the Director of Nursing revealed that the facility's wound care consultant was performing wound care in a resident's room during observation. The Director of Nursing confirmed that the cart was not to be left opened and unattended with its contents accessible to residents creating a potential accident hazard.</p> <p>During an interview on April 16, 2024, at approximately 11 AM, the Director of Nursing confirmed the potential accident hazards in the resident hallway and the presence of independently mobile residents in that same hallway. on the unit.</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41460</p> <p>Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness.</p> <p>Findings include:</p> <p>Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).</p> <p>Observations during a tour of the dry storage room was conducted with the Director of Nursing on April 16, 2024, at approximately 11:30 AM, revealed the following unsanitary practices with the potential to introduce contaminants into food and increase the potential for food-borne illness, was identified:</p> <p>The door to the dry storage room was open.</p> <p>A 5 lb. bag of chicken bread coating and a 25 lb. bag of flour were opened, and no date was noted when they were opened and put into use. The packages were not closed securely, simply loosely folded closed at the opening at the top of each bag, failing to fully protect the contents.</p> <p>A ziplock plastic bag, containing an opened package of walnuts was observed in a brown box on a metal shelf. The brown box also contained another bag of opened walnuts and loose walnuts were observed in the bottom of the box.</p> <p>The baseboard molding running along the bottom of the wall of dry storage room, beneath the metal shelving unit on the right-hand side of the room was missing, exposing dry wall and approximately a 1/2 inch gap was observed between the wall and the floor. A glue trap and mouse droppings were observed along the same wall.</p> <p>The dry storage room is located next to the kitchen.</p> <p>Observation of the kitchen revealed a grey and orange personal backpack on the metal kitchen counter next to the toaster and below the kitchen knives mounted on the wall.</p> <p>Observations of the kitchen and dry storage room were confirmed with the facility's Certified Dietary Manager on April 16, 2024, at approximately 11:45 AM.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on April 16, 2024, at approximately 12:30 PM, confirmed that the kitchen and all food storage areas should kept in a sanitary manner and all foods and beverages should be stored in a safe and sanitary manner.</p> <p>Refer F925</p> <p>28 Pa. Code 201.18 (e) (2.1) Management</p> <p>28 Pa. Code 211.6 (f) Dietary Services</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>41460</p> <p>Based on observations and interviews with resident and staff, it was determined that the facility failed to maintain an effective pest control program.</p> <p>Findings include:</p> <p>Observations during an environmental tour of the facility on April 16, 2024, at approximately 11:30 AM, down the service entrance hallway in the presence of the Director of Nursing, revealed that the doors to the kitchen, dry storage room, and mechanical room were open. Further observation revealed that the door from the mechanical room leading to the outside of the building was also open to the outside, providing a means of entry for pests.</p> <p>Observation of the dietary dry storage room revealed that there were mice droppings on the floor and on a pest glue trap located beneath a metal shelving unit on the right-hand side of the room.</p> <p>The facility's pest control company invoice/report dated March 6, 2024, failed to include information related to services provided and/or results of any inspection.</p> <p>Review of the facility's pest control company invoice/report dated April 3, 2024, indicated that service to all rooms and restrooms, service to kitchen and dining room, check all rooms for mice, and rebait exterior bait stations was completed. The report did not identify the outcome of the checks and bait stations related to presence of rodent/mice activity.</p> <p>Interview with the Director of Nursing on April 16, 2024, at approximately 12 PM confirmed the presence of rodent activity in the facility, as evidenced by by mice droppings in the facility's dietary dry goods storage room, and that the reports from the pest control company were limited in information regarding pest activity and recommendations for the facility to employ to deter and eliminate the pest activity.</p> <p>Refer F812</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p>