

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  09/20/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</b></p> <p>Based on review of clinical records, and staff interview, it was determined that the facility failed to timely notify the physician and the resident's responsible party of medication error for one resident out of 12 sampled (Resident 1).</p> <p>Findings include:</p> <p>A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</p> <p>A review of Resident 1's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 2, 2024 revealed a BIMS score of 3 (BIMS- brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00- 07 equates to severe cognitive impairment).</p> <p>A review of a facility investigative report dated September 18, 2024 at 12:38 PM revealed on September 15, 2024, the resident was given a medication not prescribed to her. It was indicated Resident 1 was given short acting insulin (a regular or short-acting insulin injection treats diabetes. It uses human-made insulin to lower the blood sugar. Regular insulin is most effective between two and three hours after injection. It reduces the blood sugar for three to six hours after it starts working) prior to lunch in error on Sunday September 15, 2024. Further it was indicated that nursing was made aware on September 18, 2024. The report failed to identify the name of the insulin, the amount administered, and which resident's insulin was given to Resident 1.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement from Employee 1, LPN (licensed practical nurse) dated September 18, 2024, revealed on Sunday September 15, 2024 Employee 2, LPN was on orientation (required supervision by licensed nurse) and preparing Resident 2's insulin and medications. Employee 1, LPN stated Employee 2, LPN asked where the resident was and Employee 1, LPN stated the resident was in the dining room where they do activities. Employee 1 stated she told Employee 2, LPN the resident would answer to her name if she asked and she assumed Employee 2, LPN would ask other staff to confirm the resident's identity. Employee 1, LPN revealed Employee 2, LPN came back to her and stated she gave the wrong resident the insulin. Employee 2, LPN stated to Employee 1, LPN that Employee 3, NA (nurse aide) had witnessed her give Resident 1, Resident 2's insulin. At that time, Employee 1 then reported the medication error to Employee 4, RN (registered nurse). Employee 1 stated that Employee 4, RN told her she spoke with the Director of Nursing (DON), and she was aware of the medication error. Resident 1 did not have a diagnosis of diabetes (is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period) and did not require insulin.</p> <p>A review of a witness statement from Employee 2, LPN dated September 18, 2024, revealed the employee was on orientation in the grey hall. The employee stated she was preparing medication for Resident 2 and asked Employee 1, LPN who the resident was. Employee 2, LPN indicated that Employee 1, LPN told her that Resident 2 responds to her name. The employee stated she went down to the activities room and called out Resident 2's name three times. The employee indicated that Resident 1 answered to the name, and she administered 12 units of insulin to Resident 1. At that time Employee 3, nurse aide asked her if she knew who that resident was. The employee stated yes. Employee 3, nurse aide stated to her, I didn't know you were helping on both halls. Employee 3, nurse aide realized at that time she gave the wrong resident the insulin. The employee indicated she told Employee 1, LPN what had happened, and they both told Employee 4, RN that Resident 1 received Resident 2's insulin.</p> <p>A review of Resident 1's clinical record revealed no documented evidence the facility had contacted the physician on September 15, 2024, to inform the physician Resident 1 received 12 units of insulin in error. Further review revealed the facility failed to notify Resident 1's representative of the medication error.</p> <p>An interview with the Director of Nursing and Nursing Home Administrator on September 20, 2024, at approximately 2:15 PM confirmed the facility failed to notify the resident's responsible party and physician of a significant medication error.</p> <p>28 Pa Code 211.12 (c)(d)(3)(5)Nursing services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 41581</b></p> <p>Based on a review of facility investigative documentation, clinical records, and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses promptly assessed and evaluated a resident after a significant medication error occurred to assure the resident received necessary care and services timely for one resident (Resident 1) and failed to implement physician's orders for wound treatments for two residents (Resident 3 and 4) out of 12 sampled.</p> <p>Findings include:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records.</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding</p> <p>the patient</p> <p>Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</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 - Some</p>	<p>A review of Resident 1's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 2, 2024 revealed a BIMS score of 3 (BIMS- brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00- 07 equates to severe cognitive impairment).</p> <p>A review of a facility investigation documentation dated September 18, 2024 at 12:38 PM revealed on September 15, 2024, the resident was given a medication not prescribed to her. It was indicated Resident 1 was given short acting insulin (a regular or short-acting insulin injection treats diabetes. It uses human-made insulin to lower the blood sugar. Regular insulin is most effective between two and three hours after injection. It reduces the blood sugar for three to six hours after it starts working) prior to lunch in error on Sunday September 15, 2024. Further it was indicated that nursing was made aware on September 18, 2024. The report failed to identify the name of the insulin, the amount administered, and which resident's insulin was given to Resident 1.</p> <p>A review of a witness statement from Employee 1 LPN (licensed practical nurse) dated September 18, 2024, revealed on Sunday, September 15, 2024 Employee 2 LPN was on orientation and preparing Resident 2's insulin and medications. Employee 1, LPN stated Employee 2, LPN asked where Resident 1 was located and Employee 1, LPN stated the resident was in the dining room doing activities. Employee 1, LPN stated she told Employee 2, LPN the resident would answer to her name if she asked and she assumed Employee 2, LPN would ask other staff member to identify Resident 2. Employee 1, LPN revealed Employee 2, LPN came back to her and stated she gave the wrong resident the insulin. Employee 2, LPN stated to Employee 1, LPN that Employee 3, a nurse aide had witnessed her give Resident 1, Resident 2's insulin. At that time, Employee 1, LPN then reported the medication error to Employee 4, RN (registered nurse). Employee 1, LPN stated that Employee 4, LPN told her she spoke with the Director of Nursing (DON), and she was aware of the medication error.</p> <p>A review of a witness statement from Employee 2, LPN, on orientation at the time, dated September 18, 2024, revealed the employee was being trained in the area identified as the gray hall. The employee stated she was preparing medication for Resident 2 and asked Employee 1, LPN who the resident was. Employee 2, LPN indicated that Employee 1, LPN told her that Resident 2 responds to her name. The employee stated she went down to the activities room and called out Resident 2's name three times. The employee indicated that Resident 1 answered to the name, and she administered 12 units of insulin to Resident 1. (Resident 1 was identified with severe cognitive impairment and was just responding to a name being called). At that time Employee 3, nurse aide, asked her if she knew who that resident was. The employee stated yes. Employee 3, nurse aide stated to her, I didn't know you were helping on both halls. Residents from all areas of the facility were located in the dining room. Employee 3 nurse aide realized at that time Employee 2, nurse aide gave the wrong resident the insulin. The employee indicated she told Employee 1, LPN what had happened, and they both told Employee 4, RN that Resident 1 received Resident 2's insulin.</p> <p>A review of a witness statement from Employee 3, nurse aide (statement not dated) indicated on September 15, 2024, the employee entered the dining room. The employee stated she observed Employee 2, LPN give Resident 1 an injection (insulin) in her right upper arm. The employee stated she asked Employee 2, LPN if she was helping the nurses on both medication carts because Resident 1 did not reside in the gray hall where Employee 2, LPN was on orientation. Employee 2, LPN walked swiftly away without a response. Employee 3, nurse aide stated she went to Employee 5, LPN at that time to tell her what she witnessed.</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 - Some</p>	<p>A review of a witness statement from Employee 5, LPN dated September 18, 2024, revealed on September 15, 2024, during the morning medication pass Employee 3, Nurse Aide pulled this employee into the clean utility closet to speak in privacy. Employee 5, LPN stated Employee 3, nurse aide told her that Employee 2, LPN gave insulin to the wrong resident. Employee 5, LPN stated she asked Employee 2. LPN if she gave Resident 1 Resident 2's insulin. Employee 2, LPN stated that she did give Resident 1, 12 units of insulin. Employee 5, LPN stated that Employee 1, LPN told Employee 4, RN about the medication error. Employee 4, RN stated to Employee 5, LPN she reached out to the DON. Employee 5 stated a couple hours passed and they were still waiting for the DON to return their call. Employee 5, LPN stated the DON finally called the facility back and told Employee 4, RN to tell Employee 5, LPN to give Resident 1 glucagon (a medication that stimulates the liver to release stored sugar into the blood, which raises blood sugar levels) mixed in with Boost high calorie supplement. The employee indicated she administered the glucagon and high calorie supplement. The resident drank 100 percent of the supplement. Further, Employee 5, LPN indicated the DON advised them not to document the medication error due to the Department of Health revisit approaching.</p> <p>A review of a witness statement from Employee 4, RN, dated September 19, 2024, revealed she was made aware by Employee 1 LPN, that Employee 2, LPN, gave insulin to Resident 1. The Employee stated she asked Employee 2, LPN if this error was true and she would not admit to it. Employee 4 RN, asked Employee 5, LPN to check Resident 1's blood sugar (no documented result noted in clinical record) and monitor the resident. Employee 4, RN stated she reached out to the DON and told her what had happened. The employee stated the DON told her education would be completed and she would follow up the next day. Employee E4 stated she gave the resident one teaspoon of glucose (sugar supplement) in boost and had the resident drink it.</p> <p>A review of the Resident 2's clinical record revealed a physician's order for Lispro insulin (a fast-acting, human-made insulin that helps regulate blood sugar levels in people with diabetes) 100 units/ml (milliliter) inject 12 units subcutaneously (under the skin) at 8:00 AM, 12:00 PM, and 5:00 PM.</p> <p>A review of Resident 1's clinical record revealed the licensed staff failed to assess Resident 1 after the resident received 12 units of insulin in error. There was no documented evidence the resident's blood sugar was monitored to ensure the resident did not have side effects from receiving Resident 2's insulin such as low blood sugar resulting in but not limited to, shakiness, sweating, and dizziness</p> <p>The facility staff failed to call the physician after the medication error had occurred. The staff provided treatment of glucagon and Boost supplement without a physician's order.</p> <p>An interview with the Director of Nursing on September 20, 2024, at approximately 12:00 PM confirmed the facility staff failed to provide a timely assessment to Resident 1 after the resident was administered Resident 2's insulin. The Director of Nursing confirmed facility staff provided medication and a supplement to Resident 1 without a physician order.</p> <p>A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included peripheral vascular disease (condition in which narrowed blood vessels reduce blood flow to the limbs) and type 2 diabetes (high blood sugar).</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 - Some</p>	<p>A review of a skin and wound note dated September 16, 2024, at 12:29 PM revealed the resident was being seen for left lower leg wounds. The resident was noted to have a venous wound (a wound on the leg or ankle caused by abnormal or damaged veins) to the left calf measuring 5.7 cm (centimeters) x 6.3 cm x 0.3 cm. The wound consultant indicated the resident is to receive the following treatment: cleanse the wound with Hibiclens (antiseptic skin cleanser), apply Vitamin A&amp;D ointment (ointment that provides a protective barrier) to intact skin on the left lower leg before the application of zinc paste wrap (bandage soaked in zinc oxide which provide soothing and cooling properties to relieve itching and soreness) to the base of the wound, secure the zinc paste wrap with an ace bandage, and change the dressing every other day.</p> <p>A review of the resident's Medication and Treatment Administration Record for September 2024 revealed the facility staff failed to implement the resident's treatment as indicated by the wound consultant. The resident had gone four days without the recommended treatment.</p> <p>A review of Resident 4's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the vulva (cancer of the female genitals).</p> <p>A review of a skin and wound note dated September 16, 2024, at 1:03 PM revealed moisture associated skin damage (MASD inflammation and erosion of the skin caused by prolonged exposure to moisture and its contents, including urine, stool, perspiration, wound exudate, mucus, or saliva). The resident was noted to have a MASD to the sacrum (area at the base of the spine) measuring 5cm x 7.5cm x 0.1cm. The wound consultant indicated the resident is to receive the following treatment: cleanse the wound with soap and water, pat dry, apply zinc based barrier cream to the base of the wound, secure with and ABD (gauze pads are used to absorb discharge), and change the dressing daily and as needed.</p> <p>A review of the resident's Medication and Treatment Administration Record for September 2024 revealed the facility staff failed to implement the resident's treatment as indicated by the wound consultant. The resident had gone four days without the recommended treatment.</p> <p>An interview with the Director of Nursing on September 20, 2024, at approximately 2:15 PM confirmed the facility staff failed to implement physician's orders for wound treatments.</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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41581</p> <p>Based on a review of clinical records, a facility investigative report, nurse competencies and staff interview, it was determined the facility failed to ensure that licensed nursing staff possessed the skills and competencies necessary to assure administration of medications accurately and safely for one resident out of 12 sampled (Residents 1).</p> <p>Findings include:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (1) undertake a specific practice only if the licensed practical nurse has the necessary knowledge, preparation, experience, and competency to properly execute the practice.</p> <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</p> <p>A review of Resident 1's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 2, 2024 revealed a BIMS score of 3 (BIMS- brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00- 07 equates to severe cognitive impairment).</p> <p>A review of a facility investigative report dated September 18, 2024 at 12:38 PM revealed on September 15, 2024, the resident was given a medication not prescribed to her. It was indicated Resident 1 was given short acting insulin (a regular or short-acting insulin injection treats diabetes. It uses human-made insulin to lower the blood sugar. Regular insulin is most effective between two and three hours after injection. It reduces the blood sugar for three to six hours after it starts working) prior to lunch in error on Sunday September 15, 2024. Further it was indicated that nursing was made aware on September 18, 2024. The report failed to identify the name of the insulin, the amount administered, and which resident's insulin was given to Resident 1.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement from Employee 2, LPN dated September 18, 2024, revealed the employee was training and on orientation in the grey hall. The employee stated she was preparing medication for Resident 2 and asked Employee 1, LPN who the resident was. Employee 2, LPN indicated that Employee 1, LPN told her that Resident 2 responds to her name. The employee stated she went down to the activities room and called out Resident 2's name three times. The employee indicated that Resident 1 answered to the name (not the resident who was prescribed the insulin), and she administered 12 units of insulin to Resident 1. At that time Employee 3, nurse aide asked her if she knew who that resident was. The employee stated yes. Employee 3, nurse aide stated to her, I didn't know you were helping on both halls. Employee 3, nurse aide realized at that time she gave insulin to the wrong resident. The employee indicated she told Employee 1, LPN what happened, and they both told Employee 4 RN, that Resident 1 received Resident 2's insulin.</p> <p>A review of the Resident 2's clinical record revealed a physician's order for Lispro insulin (a fast-acting, human-made insulin that helps regulate blood sugar levels in people with diabetes) 100 units/ml (milliliter) inject 12 units subcutaneously (under the skin) at 8:00 AM, 12:00 PM, and 5:00 PM.</p> <p>An interview with Employee 2 LPN on September 20, 2024, at 10:18 AM revealed she had just started employment at the facility on September 12, 2024. The employee stated she was by herself on the medication cart on September 15, 2024. The employee stated she prepared 12 units of Resident 2's insulin and went down to the activities room to administer it. The employee stated she called out Resident 2's name three times and Resident 1 answered. Employee 2, LPN stated she gave the insulin to the resident who had answered to the name. The employee stated she did not look at the photo because they don't always look like the resident, and she did not ask any staff to help identify the resident. The employee stated Employee 3, nurse aide asked her if she knows who she just gave insulin to. The employee stated she said yes Resident 2 and that is when Employee 3, nurse aide told the employee that she was not Resident 2 but Resident 1. The employee stated she went and told Employee 1, LPN who in return they both told Employee 4, RN that a medication error had occurred. The Employee stated that she did not have competencies completed to ensure she was competent in medication pass prior to administering medications alone. She stated she had only been working at the facility a couple of days.</p> <p>An interview with the Nursing Home Administrator (NHA) on September 20, 2024, at approximately 12:30 PM revealed the facility has an orientation check list for licensed nurses that needs to be completed prior to being assigned their duties. The NHA stated that all licensed staff are to have medication administration competencies completed with the Director of Nursing (DON) prior to administering medications without supervision.</p> <p>A review of Employee 2's, LPN employee file revealed the facility failed to complete the medication administration competencies with Employee 2, LPN prior to allowing her to safely administer medications to residents. Further review of the employee's file revealed no competencies were completed during her orientation prior to the assumption of her assignment.</p> <p>During an interview on September 20, 2024, at approximately 2:15 PM, The Nursing Home Administrator and Director of Nursing confirmed that Employee 2, LPN failed to demonstrate competency on accurately and safely administering medication for Resident 1. The facility failed to ensure that licensed nursing staff possessed the skills and competencies related to medication administration.</p> <p>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41581</p> <p>Based on a review of pharmacy documentation, clinical records and staff interviews it was determined the facility failed to implement procedures to assure timely acquiring and administration of medications to one of 12 sampled residents (Resident 4).</p> <p>Findings include:</p> <p>A review of Resident 4's clinical record revealed the resident was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the vulva (cancer of the female genitals).</p> <p>A review of physician orders dated September 13, 2024, revealed the following orders:</p> <p>Oxycodone (narcotic pain medication) 5mg (milligrams) every 6 hours as needed for moderate to severe pain.</p> <p>Ativan (anti-anxiety medication) 0.5mg every 12 hours as needed for generalized anxiety disorder.</p> <p>A review of a pharmacy delivery slip dated September 17, 2024, revealed the resident's medications were not delivered to the facility until September 17, 2024, four days after the medication was ordered. The resident did not receive the medications as ordered due to the failure of the timely arrival of the medications by the pharmacy.</p> <p>An interview with the Nursing Home Administrator on September 20, 2024, at 12:15 PM revealed the facility failed to assure timely acquiring and administration of medications to provide medications as ordered to meet the needs of residents.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.9 (a)(1)(d)(k)(l)(1) Pharmacy services.</p>		

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  09/20/2024
NAME OF PROVIDER OR SUPPLIER  Third Avenue Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  702 Third 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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</b></p> <p>Based on review of resident clinical records, select facility policy, facility investigative reports, and staff interview it was revealed the facility failed to assure that one of 12 residents reviewed were free of significant medication errors (Resident 1).</p> <p>Findings include:</p> <p>A review of a facility pharmacy policy, entitled General Dose Preparation and Medication Administration last reviewed April 30, 2024 revealed prior to the administration of medication facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, and the correct route, at the correct rate, at the correct time, for the correct resident. Further it is indicated the facility staff should verify the resident's identification (e.g. picture, armband, name).</p> <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</p> <p>A review of Resident 1's quarterly minimum data set (MDS- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated August 2, 2024 revealed a BIMS score of 3 (BIMS- brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 00- 07 equates to severe cognitive impairment).</p> <p>A review of a facility investigative report dated September 18, 2024 at 12:38 PM revealed on September 15, 2024, the resident was given a medication not prescribed to her. It was indicated Resident 1 was given short acting insulin (a regular or short-acting insulin injection treats diabetes. It uses human-made insulin to lower the blood sugar. Regular insulin is most effective between two and three hours after injection. It reduces the blood sugar for three to six hours after it starts working) prior to lunch in error on Sunday September 15, 2024. Further it was indicated that nursing was made aware on September 18, 2024. The report failed to identify the name of the insulin, the amount administered, and which resident's insulin was given to Resident 1.</p> <p>A review of a witness statement from Employee 1, LPN (licensed practical nurse) dated September 18, 2024, revealed on Sunday September 15, 2024 Employee 2, LPN was on orientation and preparing Resident 2's insulin and medications. Employee 1, LPN stated Employee 2, LPN asked where the resident was and Employee 1, LPN stated the resident was in the dining room where they do activities. Employee 1, LPN stated she told Employee 2, LPN the resident would answer to her name if she asked and that she assumed Employee 2, LPN would ask other staff who the resident was. Employee 1, LPN revealed Employee 2, LPN came back to her and stated she gave the wrong resident the insulin. Employee 2, LPN stated to Employee 1, LPN that Employee 3, nurse aide had witnessed her give Resident 1 the wrong medication. At that time, Employee 1, LPN then reported the medication error to Employee 4 RN (registered nurse). Employee 1, LPN stated that Employee 4, RN told her she spoke with the Director of Nursing (DON), and she was aware of the medication error.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Third Avenue Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  702 Third Avenue Kingston, PA 18704	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a witness statement from Employee 2, LPN dated September 18, 2024, revealed the employee was on orientation under the supervision of and LPN located in the grey hall. The employee stated she was preparing medication for Resident 2 and asked Employee 1, LPN who the resident was. Employee 2, LPN indicated that Employee 1, LPN told her that Resident 2 responds to her name. The employee stated she went down to the activities room and called out Resident 2's name three times. The employee indicated that Resident 1 answered to the name, and she administered 12 units of insulin to Resident 1. At that time Employee 3, nurse aide asked her if she knew who that resident was. The employee stated yes. Employee 3, nurse aide realized at that time she gave the wrong resident the insulin. The employee indicated she told Employee 1, LPN what had happened, and they both told Employee 4, RN that Resident 1 received Resident 2's insulin.</p> <p>A review of a witness statement from Employee 3, nurse aide (statement not dated) indicated on September 15, 2024, the employee entered the activity dining room. The employee stated she noticed Employee 2 by Resident 1 and, observed her give the resident an injection in her right upper arm. The employee stated she asked Employee 2, LPN if she was helping both nurses, not just the nurse on the gray hall. Employee 2, LPN walked swiftly away. Employee 3, nurse aide stated she went to Employee 5, LPN at that time to tell her what she witnessed.</p> <p>A review of a witness statement from Employee 5, LPN dated September 18, 2024, revealed on September 15, 2024, during the morning medication pass Employee 3, nurse aide pulled this employee into the clean utility closet. Employee 5, LPN stated that Employee 3, nurse aide told her that Employee 2, LPN gave the wrong resident insulin. Employee 5, LPN stated she asked Employee 2, LPN if she gave Resident 1 Resident 2's insulin. Employee 2, LPN stated that she did give Resident 1, 12 units of insulin. Employee 5, LPN stated that Employee 1, LPN told Employee 4, RN about the medication error. Employee 4, RN stated to Employee 5, LPN that she reached out to the DON. Employee 5, LPN stated a couple hours passed and they were still waiting for the DON to call the facility back. Employee 5, LPN stated the DON finally called the facility back and told Employee 4, RN to tell Employee 5, LPN to give Resident 1 glucagon ( a medication that stimulates the liver to release stored sugar into the blood, which raises blood sugar levels) mixed in with Boost high calorie supplement. The employee indicated she administered the medication and supplement, and the resident drank 100 percent. Employee 5, LPN indicated the DON advised not to document on the medication error due to the Department of Health revisit approaching.</p> <p>A review of a witness statement from Employee 4, RN dated September 19, 2024, revealed she was made aware by Employee 1, LPN that Employee 2, LPN gave insulin to Resident 1. The Employee stated she asked Employee 2, LPN if she gave the wrong resident insulin, and she would not admit to it. Employee 4, RN asked Employee 5, RN to check Resident 1's blood sugar and monitor the resident. Employee 4, RN stated she reached out to the DON and told her what had happened. The employee stated the DON told her education would be completed and she would follow up the next day. Employee 4, RN stated she gave the resident one teaspoon of glucose (sugar supplement) in boost and had the resident drink it.</p> <p>A review of the Resident 2's clinical record revealed a physician's order for Lispro insulin (a fast-acting, human-made insulin that helps regulate blood sugar levels in people with diabetes) 100 units/ml (milliliter) inject 12 units subcutaneously (under the skin) at 8:00 AM, 12:00 PM, and 5:00 PM.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Third Avenue Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  702 Third Avenue Kingston, PA 18704	
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's clinical record revealed no documentation on September 15, 2024, that the resident was administered Resident 2's insulin. Further there was no documentation the physician was made aware of the medication error or orders obtained to obtain the resident's blood sugar, administer medications, or supplements.</p> <p>An interview with Employee 2, LPN on September 20, 2024, at 10:18 AM revealed she had just started employment at the facility on September 12, 2024. The employee stated she was by herself on the medication cart on September 15, 2024. The employee stated she prepared 12 units of Resident 2's insulin and went to the dining room, where the resident was located, to administer it. The employee stated she called out Resident 2's name three times and Resident 1 answered. Employee 2, LPN stated she gave the insulin to the resident who had answered to the name. The employee stated she did not look at the photo because they don't always look like the resident, and she did not ask any staff to help identify the resident. The employee stated Employee 3, nurse aide asked her if she knows who she just gave insulin to. The employee stated she said yes Resident 2, and that is when Employee 3 told the employee that she was not Resident 2 but Resident 1. The employee stated she went and told Employee 1, LPN who in return told Employee 4, RN that a medication error had occurred. The employee stated that she did not have competencies completed to ensure she was competent in medication pass prior to administering medications without supervision. She stated she had only been working at the facility a couple of days.</p> <p>An interview with Employee 4, RN on September 20, 2024, at 10:30 AM revealed on September 15, 2024, Employee 1, LPN had told her that Employee 2, LPN had administered Resident 2's insulin to Resident 1. The employee stated that she called the DON and told her that Resident 1 received the wrong medication. The employee stated the DON informed her education would be provided. The employee stated she was not told to call the doctor, so she did not make him aware of the medication error. The Employee stated she had Employee 5, LPN check the resident's blood sugar and give her glucagon in Boost supplement. When asked if she received an order to obtain the resident's blood sugar and provide treatment, this employee stated no.</p> <p>An interview with Employee 5, LPN on September 20, 2024, at 10:40 AM revealed the employee stated that she was pulled aside by Employee 3, Nurse Aide and was informed that Employee 2, LPN had given Resident 1, Resident 2's insulin. The employee stated she then asked Employee 2, LPN if she had administered 12 units of insulin to the wrong resident and she confirmed she did administer the insulin to the wrong resident. She stated she was then informed by Employee 4, RN to check the resident's blood sugar and give her glucagon in a Boost supplement. The employee stated she provided that treatment however there was no documentation of the resident's blood sugar results.</p> <p>A telephone interview was conducted with Employee 1, LPN on September 20, 2024, at 12:53 PM. revealed she was instructed by Employee 4, RN to let Employee 2, LPN administer medications on September 15, 2024. Employee 1, LPN stated Employee 4, RN told her Employee 2, LPN, who was on orientation, she needed to learn. The employee stated Employee 2, LPN asked where Resident 2 was, and she stated she told Employee 2, LPN she was in the activities room. The employee stated the next thing she knew Employee 2, LPN came up to her and stated I just gave the wrong resident the insulin. The employee stated at that time she reported to Employee 4, RN that Resident 1 had received Resident 2's insulin. The employee indicated Employee 4, RN told her the DON was aware and she would make the regional nurse aware.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Third Avenue Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  702 Third Avenue Kingston, PA 18704	

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1 received 12 units of insulin which was not prescribed to her. The resident did not have a diagnosis to require insulin.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on September 20, 2024 at approximately 2:15 PM confirmed that Employee 2, LPN who at the time was on orientation, administered the incorrect medication to Resident 1, failing to ensure the resident was free from significant medication errors.</p> <p>Cross Refer F684, F726, F580</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services.</p> <p>28 Pa. Code 211.9 (a)(1)(d) Pharmacy 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** 41581</b></p> <p>Based on review of clinical records and staff interview, it was determined the facility failed to maintain accurate and complete clinical records, according to professional standards of practice for one of 12 sampled residents (Resident 1).</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient record to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments, Clinical problems, Communications with other health care professionals regarding the patient, Communication with and education of the patient, family, and the patient's designated support person and other third parties.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.11 (a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of following functions: (4) Carries out nursing care actions which promote, maintain, and restore the well-being of individuals (6)(b) The registered nurse is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and Subsection 21.18. (a)(5) document and maintain accurate records.</p> <p>According to the Title 49, Professional and Vocational Standards, Department of State, Chapter 21 State Board of Nursing Subsection 21.145. (a) The licensed practical nurse (LPN) is prepared to function as a member of a health-care team by exercising sound nursing judgement based on preparation, knowledge, skills, understanding and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place.</p> <p>A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnosis to include Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills).</p> <p>A review of a facility investigative report dated September 18, 2024 at 12:38 PM revealed on September 15, 2024, the resident was given a medication which was not prescribed to her. It was indicated Resident 1 was given short acting insulin prior to lunch in error, on Sunday September 15, 2024. Further it was indicated that nursing was not made aware on September 18, 2024. The report failed to identify the name of the insulin, the amount administered, and which resident's insulin was given to Resident 1.</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>A review of a witness statement from Employee 5, LPN dated September 18, 2024, revealed on September 15, 2024, during the morning medication pass Employee 3, Nurse Aide pulled this employee into the clean utility closet to speak in privacy. Employee 5, LPN stated Employee 3, nurse aide told her that Employee 2, LPN gave insulin to the wrong resident. Employee 5, LPN stated she asked Employee 2, LPN if she gave Resident 1 Resident 2's insulin. Employee 2, LPN stated that she did give Resident 1, 12 units of insulin. Employee 5, LPN stated that Employee 1, LPN told Employee 4, RN about the medication error. Employee 4, RN stated to Employee 5, LPN she reached out to the DON. Employee 5 stated a couple hours passed and they were still waiting for the DON to return their call. Employee 5, LPN stated the DON finally called the facility back and told Employee 4, RN to tell Employee 5, LPN to give Resident 1 glucagon (a medication that stimulates the liver to release stored sugar into the blood, which raises blood sugar levels) mixed in with Boost high calorie supplement. The employee indicated she administered the glucagon and high calorie supplement. The resident drank 100 percent of the supplement. Further, Employee 5, LPN indicated the DON advised them not to document the medication error due to the Department of Health revisit approaching.</p> <p>A review of the resident's clinical record revealed the facility failed to document the medication error on September 15, 2024. The clinical record failed to identify what time the medication error occurred, what medication Resident 1 received in error, or the dosage of medication the resident received. Further there was no documentation that the resident's physician was notified after the resident received the wrong medication. The record also failed to indicate if the resident sustained any side effects from receiving medication that was not prescribed for her.</p> <p>A review of the resident's Medication Administration Record for September 2024, failed to identify the resident received blood glucose monitoring, administration of glucagon gel, or Boost high calorie supplement as indicated by Employee 5,LPN.</p> <p>An interview with the Nursing Home Administrator and Director of Nursing on September 20, 2024, at approximately 2:15 PM confirmed the facility's nursing staff failed to document consistently and accurately in the residents' clinical records. As a result, the residents' clinical records were inaccurate and incomplete.</p> <p>28 Pa. Code 211.5 (f)(iii) Medical records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services.</p>		