STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395905	A. Building B. Wing	12/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Third Avenue Health & Rehab Center	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, facility investigative reports, clinical records, and staff interviews, it was determined the facility failed to ensure a complete and accurate investigation was conducted into an allegation of misappropriation of medication for one of ten sampled residents (Resident 1).Findings included: A review of a facility policy entitled Pennsylvania Resident Abuse revealed it is the policy of the facility to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. The policy further defined misappropriation as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Further review of the policy revealed the person investigating an incident is to interview the residents, the accused, and all witnesses. The policy stated that witnesses generally include anyone who witnessed or heard about the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. The facility would obtain written statements from the residents, if possible, the accused, and each witness. A review of Resident 1's clinical record revealed admission on [DATE], with diagnoses including ambulatory dysfunction secondary to prosthetic joint infection of the left hip (difficulty walking due to complications of hip surgery). The admission Minimum Data Set (MDS-a federally mandated standardized assessment used to plan resident care) dated July 30, 2025, indicated the resident was cognitively intact with a BIMS (Brief Interview for Mental Status-a tool assessing attention, orientation, and recall) score of 15, a score of 13-15 equates to being cognitively intact. A review of the resident's physician orders initially dated July 27, 2025, indicated the resident was to receive Oxycodone (a narcotic pain medication) 5 milligrams(mg) every 4 hours as needed for pain. A review of a grievance filed by Resident 1 dated July 30, 2025, revealed the resident reported that at 11:00 PM, he requested his PRN pain medication from a female nurse but never received it. The grievance further documented the resident again told a female aide at approximately 2:00 AM that he wanted his pain medication, but his request again went unanswered. The grievance also noted conflicting information when Resident 1 later reported he had asked a male nurse for his medication. The facility did not identify these individuals, document efforts to determine their identities, or reconcile these inconsistencies.A typed, undated note attached to the grievance, authored by the Director of Nursing (DON), concluded that the allegation was unsubstantiated and stated the resident had been sleeping between 2:15 AM and 6:00 AM, with the next medication request occurring at 11:00 AM on July 31, 2025. The note further stated that to prevent future occurrence, two employees will be assigned to administer the resident's medications.A review of Resident 1's July 2025 Medication Administration Record (MAR) revealed documentation that the PRN Oxycodone was administered on July 30, 2025, at 9:59 PM by Employee 1 (LPN) and again on July 31, 2025, at 2:20 AM by Employee 2 (RN), despite Resident 1's consistent report that he had not received the medication that evening. A review of a facility investigative documentation contained a single witness statement from Employee 3 (LPN), who indicated she had not been informed that Resident 1 requested medication throughout the night shift and stated that Resident 1 told her he had asked a male nurse for his pain medication. There was no documented evidence that either Employee 1 or Employee 2, both of whom recorded medication administration were interviewed or asked to provide written statements. The facility failed to conduct a complete and accurate investigation by not identifying the staff members referenced by the resident as male or female, not obtaining written statements from all potentially involved staff, and not reconciling conflicting reports about the administration of the medication. This failure resulted in an incomplete investigation that did not substantiate or disprove the allegation in accordance with facility policy. An interview with the Nursing Home Administrator and Director of Nursing on October 7, 2025, at approximately 11:00 AM confirmed the facility was unable to provide any additional witness statements from staff who documented the administration of the medication despite the resident's claim he did not receive any medication and acknowledged that the investigation contained no evidence identifying the male or female individuals referenced by the resident. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident Rights 28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(c)(d)(5) Nursing Services