| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395905 | A. Building<br>B. Wing | 07/31/2024 |

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| Third Avenue Health & Rehab Center | 702 Third Avenue<br>Kingston, PA 18704 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944<br><br>Based on observation and staff interview, it was determined that the facility failed to maintain a safe, sanitary, and orderly environment in the resident's main dining room area.<br><br>Findings include:<br><br>Observations of the resident's main dining room on [DATE], at 9:30 a.m., revealed four grey-pattered chairs with leather-like seats that appeared significant worn.<br><br>Also, observed that the dining room windowpanes had significant debris and deceased bugs inside and the white colored blinds that covered the exit door window had cobwebs and live spiders adhered to the surface.<br><br>Observed that the grey garbage inside of the resident's main dining room had splatter and debris adhered to the lid and the floor was sticky.<br><br>Further observations of the resident's main dining room area on [DATE], at 12:30 p.m., revealed that the above observations continued.<br><br>Interview with the Nursing Home Administrator on [DATE], at 1:39 p.m., confirmed the above observations and confirmed that the resident's dining area should be maintained in a clean and homelike environment.<br><br>28 Pa Code 207.2(a) Administrator's responsibility |

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 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on a review of clinical records, select facility policy and investigative reports and staff interview, it was determined that the facility failed to implement procedures to identify and prevent potential misappropriation of resident property, medications, for one resident out of 13 sampled (Resident 49).<br><br>Findings include:<br><br>The facility policy for Abuse Protection, reviewed by the facility April 8, 2024, 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 injury. Facility staff must immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in the policy. All allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing, and to the applicable state agency.<br><br>A review of the clinical record revealed Resident 49 was admitted to the facility on [DATE], with diagnoses of wedge compression fracture of second lumbar vertebra, anxiety, and dysphagia (difficulty swallowing).<br><br>The resident had a physician order dated June 15, 2024, for hydrocodone-acetaminophen 5/325 mg orally every 4 hours as needed for pain.<br><br>A review change of shift controlled substance inventory sheet revealed that on June 17, 2024, on the 3p to 11p shift, Resident 49 received a controlled substance from the pharmacy. The sheet failed to identify the medication name, the medication strength, or which nurse added the medication to the substance inventory, or which nurse verified that the medication was added to the inventory.<br><br>Review of pharmacy Proof of Delivery form indicated that the facility received 30 hydrocodone-acetaminophen 5mg-325mg tablets on June 17, 2024, which was received by Employee 1, registered nurse, at 2:18 PM. The medication card containing the 30 hydrocodone-acetaminophen 5mg-325mg tablets as well as the controlled drug sign-out sheet was identified as missing on June 25, 2024, at 2:18 PM.<br><br>A review of a facility investigation dated June 25, 2024, nursing staff notified facility administration that Resident 49's Hydrocodone-Acetaminophen 5mg-325mg tablets (30 tablets) and the controlled drug sign out sheet were missing from the medication cart and an investigation was initiated.<br><br>A witness statement dated June 25, 2024, (no time indicated) from Employee 10 (LPN) revealed that the nurse stated that Resident 49 expressed that he had an increase in pain. According to the statement, when this nurse went to pull Vicodin [hydrocodone-acetaminophen] from the narcotic box, there was no Vicodin available for resident. This nurse asked resident if they had used the Vicodin, and the resident stated that they had not. The Vicodin order was still in the computer. There was no sheet for the completed Vicodin card found. This nurse informed the ADON [assistant director of nursing] the Vicodin card with 30 tablets was seen on Thursday, June 20, 2024, during the 7-3 shift.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of a controlled substance shift to shift count sheet revealed that on June 22, 2024, 7 AM to 3 PM shift, Employee 5 (LPN) the off going 7 A.M. to 3 P.M. nurse signer and Employee 7 (LPN) the oncoming 3 P. M. to 11 P.M. nurse signer, the 28 was crossed out and 27 was written in its place, which indicated that there were 27 cards of narcotic medication in the cart.<br><br>Further review of the controlled substance sheet failed to provide evidence that a narcotic medication card was removed from the cart.<br><br>There was no evidence that on June 22, 2024, during the shift-to-shift narcotic count, the discrepancy in the count of cards was reported to administration. The discrepancy was not identified and/or reported until June 25, 2024, when Employee 3 went to administer the medication to the resident.<br><br>A witness statement provided by Employee 5 (LPN), dated June 25, 2024, stated that on June 20, 2024, I did not destroy anything, and it was not exhausted, and in an additional interview on June 24, 2024, she did not recall the count and counted with Employee 8.<br><br>A written witness statement provided by Employee 9 (RN), dated June 27, 2024, stated that while counting the narcotic cart with Employee 6 (LPN) on June 22, 2024, at 7 PM, she did not have a pen in my hand at the time to sign the book. When the 11 o'clock [PM] shift nurse came in, Employee 4 (LPN), I signed the book and corrected the card count while the nurse was at the cart with me.<br><br>There was no evidence that the facility nursing staff reported the discrepancy in narcotic medication cards to administration. According to the controlled substance inventory record, there was no evidence to support that the number of narcotic medication cards changed from 28 to 27.<br><br>Resident 49 had not requested the narcotic pain medication prior to June 25, 2024. A supply of the medication was provided by the pharmacy.<br><br>Further review of the facility investigation, which included review of witness statements, revealed that the nursing staff failed to consistently complete shift-to-shift narcotic reconciliation according to facility policy.<br><br>The investigation conclusion dated June 26, 2024, revealed that the facility determined that the misappropriation of property was confirmed, however a perpetrator was not identified.<br><br>Despite the education provided by facility administration to all licensed nursing staff during the investigation, at the time of survey ending July 31, 2024, review of the shift change controlled substance inventory sheets revealed that the nursing staff failed to be complete the shift-to-shift narcotic inventory accordingly.<br><br>28 Pa. Code 201.29 (a)(c) Resident rights<br><br>28 Pa. Code 201.18 (e)(1) Management<br><br>28 Pa. Code 211.9 (a)(1)(b)(d)(k) Pharmacy services |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929<br><br>Based on observation, clinical record review and staff interview, it was determined that the facility failed to timely develop and implement a person-centered care plan to meet one resident's current needs for two of 13 sampled resident (Resident 26).<br><br>Findings including:<br><br>Clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses to include dementia.<br><br>Review of quarterly Minimum Data Set Assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 18, 2024, revealed that Resident 26 was severely cognitively impaired with a BIMS score (BIMS (Brief Interview for Mental Status) is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility) of 0 and required assistance from staff for activities of daily living.<br><br>An observation of Resident 26's room on July 30, 2024, at approximately 10:30 a.m., revealed the resident's bed was against the wall. During an interview with the Director of Nursing on July 30, 2024, she indicated the resident's bed was against the wall as a fall prevention measure.<br><br>A review of the resident's current plan of care regarding falls, initially dated May 15, 2024, did not include any reference to the residents bed being placed against the wall as a preventative measure.<br><br>There was no evidence at the time of the survey that the survey that Resident 26's care plan had been updated to reflect the bed being placed against the wall for fall prevention.<br><br>During an interview on July 31, 2024, at 12 PM, the Director of nursing confirmed that the resident's fall prevention care plan was developed to accurately reflect current interventions.<br><br>28 Pa Code 211.12 (5) Nursing Services<br><br>41460<br><br>Resident #37<br><br>FTag Initiation<br><br>07/31/24 11:31 AM resident noted to be on palliative care. no order for same, no care plan for same. provided on 7/30/24 from facility, which confirmed were not developed and/or implemented accordingly. |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on clinical record review and staff interview, it was determined that the facility failed to complete a discharge summary, which included a recapitulation of the resident's stay, the course of illness, corresponding treatment, discharge instructions, and a post-discharge care plan for one of three discharged resident records reviewed (Resident 23).<br><br>Findings include:<br><br>A review of the closed clinical record revealed that Resident 53 was admitted to the facility on [DATE], with diagnoses including MRSA infection, pneumonia, and heart failure, and discharged to home on May 25, 2024.<br><br>A review of Resident 53's physician orders upon discharge revealed that the following medications were prescribed; amiodarone 200mg daily, amlodipine 5mg daily, calcitriol 0.25mcg weekly on Monday, Eliquis 5mg two times a day, furosemide 40mg daily, levothyroxine 75mcg daily, metoprolol succinate 50mg daily, and potassium chloride 10meq two times a day.<br><br>Review of the closed record failed to provide evidence of disposition of the resident's prescription medication upon discharge. There was no evidence that the medication was exhausted, sent back to pharmacy, destroyed, or sent home with the resident.<br><br>Additional review of the closed clinical record failed to provide evidence that the resident and/or resident representative were provided with a summary of the resident's stay, medication tips and treatments, medication information, functional mobility, nutrition, and activities.<br><br>At the time of the survey ending July 31, 2024, there was no documented evidence that a discharge summary was provided to the resident or the resident's representative, which included a complete recapitulation of the resident's stay which included the course of illness, corresponding treatment, complete nutrition and activities information, and written discharge instructions related to medications to ensure the resident transitioned safely from the facility to home.<br><br>During an interview conducted on July 31, 2024, at approximately 2:00 PM, the nursing home administrator was not able to provide documented evidence that a discharge summary or disposition of medications was completed for Resident 53.<br><br>28 Pa. Code 211.12 (d)(3)(5) Nursing services |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on review of clinical records and staff interview it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses accurately administered prescribed medication to one of 13 sampled residents (Resident 13).<br><br>Findings included:<br><br>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: (5) Document and maintain accurate records.<br><br>Review of the clinical record revealed that Resident 13 was admitted to the facility on [DATE], with diagnoses which included stroke, hypertension, and anxiety.<br><br>A physician order dated June 13, 2024, was noted for Metoprolol tartrate 25mg administer 1/2 tab (12.5mg) orally two times a day for diagnosis of hypertension. Hold the medication for systolic blood pressure (SBP - top number on blood pressure reading) less than 110 or heart rate less than 60.<br><br>Review of Resident 13's Medication Administration Record for the month of June 2024, revealed that there was no documented evidence that the nursing staff had monitored the resident's blood pressure or heart rate prior to the administration of the medication to ensure administration was within the physician prescribed parameters June 13 through June 30, 2024.<br><br>Review of Resident 13's Medication Administration Record for the month of July 2024, revealed that there was no documented evidence that the nursing staff had monitored the resident's blood pressure or heart rate prior to the administration of the medication from July 1 through July 9, 2024.<br><br>Interview with the Director of Nursing on July 31, 2024, at approximately 11:30 a.m. confirmed that there was no evidence that Resident 13's blood pressure medication was administered by the licensed nurses as prescribed by the physician.<br><br>28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services<br><br>28 Pa. Code 211.10(a)(c)(d) Resident care policies<br><br>28 Pa. Code 211.5 (f) Medical records |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929<br><br>Based on clinical record and select facility policy review and staff interview, it was determined that the facility failed to clinically justify the use of a foley (indwelling) catheter for two of 4 sampled residents with catheters (Resident 7 and 24).<br><br>Findings include:<br><br>Review of Resident 7's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses to have included dementia (is a term for a group of diseases and conditions that affect your thinking, memory, reasoning, personality, mood, and behavior), dysphagia (difficulty swallowing), and major depressive disorder (is a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>A review of a hospital urology consult dated February 24, 2024, revealed that Resident 7 had a urinary tract infection (UTI - is a sudden and severe inflammation of kidney due to a bacterial infection) due to use of a Foley catheter (is a device that drains urine from the bladder into a collection bag outside of the body when an individual has difficulty urinating on their own or for various medical reasons) and retention and recommended to follow up with primary care provider and urology.<br><br>A review of a Resident 7's annual MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 6, 2024, revealed that Bowel and Bladder - Urinary Continence was coded that the resident required an indwelling catheter.<br><br>Further review of Resident 7's clinical record revealed a urology consult dated May 22, 2024, related to cannot remove, failed void trial, unable to void and maintain catheter.<br><br>Resident 7's clinical record failed to include documented evidence to clinically justify the use of a Foley catheter.<br><br>Review of Resident 24's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses to have included kidney disease.<br><br>A review of a residents medication administration record revealed the resident was admitted to the facility on [DATE], from the hospital with a foley catheter.<br><br>Further review of Resident 24's clinical record revealed a nursing progress note dated June 25, 2024, related to the resident failed void trial, unable to void. Further review of nursing progress notes revealed a message was left at urology office, however there was no further indication that a urology appointment had been scheduled.<br><br>Resident 24's clinical record failed to include documented evidence to clinically justify the use of a Foley catheter.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview with the director of nursing (DON) on July 30, 2024, at 9:58 a.m., confirmed that Resident 7's and 24's clinical record failed to include a clinical diagnosis to justify chronic use of a Foley catheter.<br><br>28 Pa. Code 211.12 (d)(3)(5) Nursing services<br><br>28 Pa. Code 211.10 (a)(c)(d) Resident care policies |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944<br><br>Based on a review of clinical records and select facility policy review and staff interview, it was determined that the facility failed to timely respond to a resident's increased level of pain and provide an effective pain management to alleviate pain for one resident of 13 residents sampled (Resident 52).<br><br>Findings include:<br><br>Review of a facility policy entitled Pain Assessment and Management Protocol provided by the facility on July 31, 2024, indicated that any resident admitted to the facility would be assessed for pain and/or the potential for pain for the resident to reach and maintain his/her highest practicable level of physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The physician/provider will be notified of new onset of pain or significant increase in pain as appropriate.<br><br>A review of Resident 52's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (is a medical emergency caused by a blockage in a blood vessel that supplies blood to a region of the brain), transient cerebral ischemic attack (TIA, is a temporary blockage of blood flow to the brain by a clot that usually dissolves on its own or gets dislodged, and the symptoms usually last less than five minutes and is a warning stroke signaling a possible full-blown stroke ahead), and cerebral atherosclerosis (is a disease that occurs when the arteries in the brain become hard, thick, and narrow due to the buildup of plaque (fatty deposits) inside the artery walls which decreases the amount of blood flow to certain areas of the brain and if the buildup becomes too severe, it can block flow and cause an ischemic stroke).<br><br>A review of physician's admission orders for Resident 52 dated June 16, 2024, for acetaminophen [(Tylenol) an over-the-counter pain medication used to manage mild to moderate pain] 325 milligrams (mg) administer two tablets (650 mg) by mouth every six hours as needed for headache/pain.<br><br>A review of an incident report completed by Employee 1, a Registered Nurse,<br><br>June 18, 2024, at 9:30 p.m., revealed that she was notified by a Nurse Aide (NA) that Resident 52 was trying to get out of bed and saying that he wanted to go to work and upon returning to the resident's room, found him laying on the floor on his left side, slightly on his buttocks. Resident 52 was confused and was talking about Satan getting him and needing to go to the bathroom. Employee 1 indicated that the resident was assessed with no redness, edema, or ecchymosis noted with complaints of left knee pain and discomfort to the left thigh area. Resident was able to bend the leg back, but not able to fully extend straight and was guarding area with his hand. Physician was notified and ordered x-rays to the left hip and knee.<br><br>Further review of the incident report revealed that Resident 52's wife (responsible party) was notified and stated that sometimes he got confused, especially at night. Employee 1 indicated that Resident 52 was last seen at 9:15 p.m. and was repositioned and offered his urinal.<br><br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | X-ray results reported June 19, 2024, at 9:49 a.m., indicated negative left hip fracture and limited assessment of the knee, no fracture.<br><br>A review of occupational therapy treatment encounter notes completed by Employee 2, an Occupational Therapist (OT), dated June 19, 2024, at 4:51 p.m., revealed precautions related due to the resident's fall at this facility after admission and reports severe left thigh area pain at a reported pain level of 10 out or 10 pain with negative x-rays for fracture. Additionally, the Employee 2 indicated that nursing was notified of the resident's complaints of severe pain level.<br><br>There was no documented evidence that nursing was notified of Resident 52's complaints of severe 10/10 pain level to the left thigh area and that resident's attending physician was notified to address increased pain for further pain management interventions.<br><br>Review of occupational therapy treatment encounter notes completed by Employee 2, dated June 20, 2024, at 3:14 p.m., indicated that the resident reported complaints of severe left thigh area pain at a reported pain level of 10/10 and unable to pivot and indicated that nursing was aware.<br><br>There was no documented evidence that nursing was notified of Resident 52's complaints of severe 10/10 pain level to the left thigh area and that resident's attending physician was notified to address increased pain for further pain management interventions.<br><br>A review nurses progress notes in Resident 52's clinical record completed by Employee 3, a RN, dated June 24, 2025, at 2:28 p.m., revealed that the resident's wife was asking about applying ice to left hip and that the resident had a bruise there from a fall on June 19, 2024. The attending physician's Certified Registered Nurse Practitioner (CRNP) was made aware with new order received to apply cool compress for 20-minutes every two hours and as needed.<br><br>Further review of Employee 2's occupational therapy encounter notes for Resident 52 dated June 24, 2024, at 5:02 p.m., indicated that pivot was attempted and assistance of two staff and that the resident was not able to safely turn and sit and continued to not that the resident had 10/10 pain of his left hip and observed bruising the area and had limited movement of left lower extremity and noted that nursing was aware of same.<br><br>Further review nurses progress notes in Resident 52's clinical record completed by Employee 3, dated June 25, 2024, at 10:31 a.m., revealed that the CRNP was in facility and saw Resident 51 due to complaints of left hip discomfort and orders given for X-ray hips with or without pelvis.<br><br>A review of x-ray results dated June 25, 2024, at 1:36 p.m., revealed a intertrochanteric fracture (is a type of broken hip) of the neck of the left femur and Resident 52 was transported to the hospital for an evaluation.<br><br>A review of Resident 52's electronic Medication Administration Record (MAR, or eMAR for electronic versions), commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional) dated June 18, 2024, through June 25, 2024, revealed that the resident was administered prn Tylenol four times for a noted pain level of 3 (mild pain).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395905 | A. Building<br>B. Wing | 07/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Third Avenue Health & Rehab Center | 702 Third Avenue<br>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.

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility failed to timely respond to Resident 52's complaints of severe pain (10/10) and develop effective pain management interventions to relieve severe pain.<br><br>During an interview with the facility's Director of Nursing (DON) on July 31, 2024, confirmed that the facility failed to respond timely and effectively address Resident 52's increased reports of severe left hip pain.<br><br>28 Pa. Code 211.12 (d)(3)(5) Nursing Services |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929<br><br>Based on a review of clinical records and staff interview, it was determined that the facility failed to develop and implement an effective individualized person-centered plan to address a resident's dementia-related behavioral symptoms for one out of 13 residents reviewed (Resident 29).<br><br>Findings include:<br><br>A review of Resident 29's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (progressive brain disorder that affects memory, thinking, and behavior)<br><br>A review of Resident 29's Quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 2, 2024, revealed the resident was severely cognitively impaired.<br><br>A review of progress notes in the resident's clinical record dated from February 01, 2024 to July 30, 2024, revealed that the resident exhibited behaviors of spitting, striking out, biting, and agitation.<br><br>The resident's current care plan, in effect at the time of the survey ending July 31, 2024, did not address her diagnosis of Alzheimers Disease.<br><br>The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms.<br><br>The facility failed to demonstrate the provision of necessary care and services, including individualized interdisciplinary non-pharmacological approaches to care, purposeful and meaningful activities, that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. There was no evidence that the facility provided the resident with specialized services and supports, such specialized activities, nutrition, and environmental modifications, based on the individual's abilities and dementia related behaviors<br><br>Interview with Nursing Home Administrator on July 31, 2024, at approximately 10:00 a.m., confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia-related behaviors.<br><br>28 Pa Code 211.12 (d)(3)(5) Nursing services |

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| Third Avenue Health & Rehab Center | 702 Third Avenue<br>Kingston, PA 18704 |

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|---|---|
| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929<br><br>Based on review clinical records and staff interviews, it was determined that the facility failed to ensure that a resident was free from unnecessary psychoactive drugs by failing to ensure the presence of clinical rationale for the continued use of an as needed psychotropic medication for one of five residents reviewed (Resident 29).<br><br>Findings include:<br><br>A review of Resident 29's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (progressive brain disorder that affects memory, thinking, and behavior)<br><br>Review of Resident 29's clinical record revealed a physician's order for alprazolam (used to treat anxiety) tablet 0.25 MG give 1 tablet by mouth every 12 hours as needed for Anxiety with a start date of April 02, 2024, and no end date .<br><br>Review of the June 2024 Medication Administration Records (MAR) revealed that the medication (alprazolam) was administered to the resident four times during the month of June 2024.<br><br>Review of the July 2024 Medication Administration Records (MAR) revealed that the medication (alprazolam) was administered to the resident one time during the month of July 2024.<br><br>Review of the physician's notes for the months of June and July 2024, revealed that the physician failed to document the clinical rationale for the continued use or identify the need for the extended duration for the prn (as needed) order for the psychoactive drug without re-evaluation of its necessity.<br><br>An interview was conducted with the Director of Nursing on July 31, 2024, at approximately 12:30 p.m. verified that there was no physician documentation of the clinical rationale for the prn medication to be used more than 14 days.<br><br>28 Pa. Code 211.9 (k) Pharmacy services.<br><br>28 Pa Code 211.5 (f) Medical records<br><br>28 Pa. Code 211.2 (d)(7) Medical director |

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| Third Avenue Health & Rehab Center | 702 Third Avenue<br>Kingston, PA 18704 |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460<br><br>Based on review of clinical records and staff interview, it was determined that the facility failed to follow-up with required dental services for one Medicaid payor source out of 13 residents sampled. (Resident 37).<br><br>Findings include:<br><br>Review of Resident 37's clinical record indicated that the resident was admitted to the facility on [DATE], and that the resident's payor source was Medicaid.<br><br>Review of Resident 37's clinical record revealed documentation dated May 9, 2024, at 6:04 PM, which indicated that the mobile dental services had been running behind and that it was now too late to come to facility for dental checks and resident's two extractions. Stated they would be calling the facility to reschedule the day that they would be in to complete. provided by the facility indicated that the resident was last seen by a dentist on October 26, 2022.<br><br>A review of Oral Hygiene Consult Sheet dated May 16, 2024, indicated that the resident had no dental complaints. Recommendations included to continue care, brush daily, and continue with routine cleanings. There was no evidence that the resident's need for two dental extractions was addressed.<br><br>Review of Resident 37's clinical record revealed that the resident's meal intake and/or nutritional status was impacted by the need for two teeth to be extracted. Further review did not identify concerns with resident complaints of pain/discomfort related to the need to have teeth extracted.<br><br>At time of survey ending July 31, 2024, there was no documented evidence that the facility followed up with dental services related to the need for Resident 37 to have teeth extracted as noted on May 9, 2024.<br><br>28 Pa Code 211.5 Dental Services |