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	05/30/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52054 Based on clinical record review, observation, and staff interviews, it was determined the facility failed to ensure that one resident out of 18 sampled (Resident 26) was afforded the right to participate in care and treatment decisions, to be fully informed of treatment, and to make choices about preferred treatment options. The findings include: Review of the clinical record revealed that Resident 26 was admitted to the facility on [DATE], with diagnoses to include osteoarthritis (a joint disease characterized by the breakdown of cartilage causing pain and stiffness), and chronic pain. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 2, 2025, revealed that Resident 26 was severely cognitively impaired with a BIMS score of 15 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information (a score of 13-15 indicates a resident is cognitively intact). A review of Resident 26's clinical record revealed an order for Torsemide 20mg (diuretic medication used to help the body eliminate excess salt and water) to be administered as two tablets by mouth once daily as needed. On May 27, 2025, at approximately 8:45 a.m., during observation of the morning medication pass, Employee 4 (Licensed Practical Nurse) was observed placing multiple medications, including Torsemide, into a medication cup and offering them to Resident 26. During this interaction, Resident 26 expressed concern and stated he did not want to take his water pill because it would cause him to urinate excessively throughout the day. In response, Employee 4 stated, There is no water pill in here, please take your medications, and proceeded to administer the medications, including the Torsemide, despite the resident's verbal refusal. An interview conducted with Employee 4 following the observation confirmed that she administered the Torsemide to Resident 26. She further stated that she was unaware Torsemide was a diuretic, commonly referred to by residents as a water pill. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 27, 2025, at approximately 12:00 p.m., the Nursing Home Administrator (NHA) confirmed the nurse failed to provide Resident 26 with the opportunity to refuse the medication and acknowledged the resident's right to participate in treatment decisions was not upheld. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility for one resident (Resident 53) out of 13 residents sampled. Findings include: Review of the facility Restorative Nursing Services Policy last reviewed February 13, 2025, indicated residents who could benefit from the nursing restorative programs can be identified at the following times: on admission, when other assessment are required such as a Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care), from the 24-hour report and the change of shift report, at morning standup meeting, at care planning, and other resident-focused meetings, at risk management meetings such as behavior management, nutrition at risk, and during weekly restorative weekly reviews. If appropriate the resident will begin the restorative program. Care plan will be developed. Orders are not needed for resident to participate in restorative programming. Review of the clinical record revealed that Resident 53 was initially admitted to the facility on [DATE], transferred to the hospital on March 23, 2025, and readmitted to the facility on [DATE], with diagnoses which include obstructive hydrocephalus (a condition where the normal flow of cerebrospinal fluid is blocked within the brain's ventricles or the pathways connecting them leading to a buildup of fluid and increased pressure within the brain) with placement of a ventricular intracranial communicating shunt (device used to treat hydrocephalus), anxiety, and depression. Review of an admission MDS dated [DATE], indicated the resident was severely cognitively impaired and was non-ambulatory. Further review of the clinical record revealed that Physical Therapy was provided to the resident from April 16, 2025, until May 15, 2025. Review of the resident's Physical Therapy Discharge Summary dated May 15, 2025, indicated at the time of discharge the resident could ambulate 25 feet with contact guard assistance (a hand or two is placed on the resident's body to help with balance). Prognosis to maintain current level of functioning was described as good with consistent staff follow-through. Discharge recommendations included gait (ambulation) with rolling walker (walker with wheels) to bathroom or short distances. Review of a care plan initially dated May 19, 2025, revealed the resident required training and skill practice in walking with a goal to walk in room with the assistance of one staff with a rolling walker for 10 feet. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 53's Point of Care Restorative Nursing Report for Walking dated May 19, 2025, through May 29, 2025, indicated that staff were to document the distance and number of minutes the resident walked on the first and second shift. The report indicated the resident ambulated on only four of 11 days. Reasons for not being ambulated included refusal, deferred due to condition, and unavailable. Further review of the clinical record revealed no documented evidence that licensed staff were aware that the resident's newly implemented ambulation program was not being implemented as planned to ensure the resident's ambulation goal was met to the extent possible. Interview with the Assistant Director of Nursing (ADON) on May 30, 2025, at approximately 1:30 PM failed to provide documented evidence that Resident 53's restorative ambulation program was implemented as planned. The ADON failed to provide documented evidence that Resident 53's reasons for refusal to ambulate or episodes of staff not providing ambulation assistance to the resident as planned were evaluated at the time of occurrence by licensed staff to ensure the resident's goals for ambulation are met to the extent possible. 28 Pa. Code: 211.5(f)(viii) Medical records 28 Pa Code 211.12(c)(d)(5) Nursing services

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52054 Based on review of clinical records, facility policies, documentation provided by the facility, and staff interviews, it was determined the facility failed to consistently provide adequate supervision and implement appropriate, individualized fall prevention interventions based on assessed needs to ensure the safety of one of 18 sampled residents (Resident 50), resulting in multiple unwitnessed falls and significant injury, including a traumatic subdural hemorrhage and multiple fractures of the arm. Findings include: A review of the facility policy titled Fall Prevention and Management Policy, last reviewed by the facility February 13, 2025, revealed it is the policy of the facility to assist in fall management and prevention. The policy indicated an individualized, person-centered nursing care plan will be initiated and/or updated by the interdisciplinary team upon readmission to the facility. A clinical record review revealed Resident 50 was admitted to the facility on [DATE], with diagnoses including chronic kidney disease (gradual loss of kidney function), and history of recurrent falls. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 11, 2024, revealed that Resident 50 was severely cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). A review of a Fall Risk assessment dated [DATE], revealed the resident lacks understanding of her physical and cognitive limitations and was assessed as being at high risk for falls. A review of the resident's plan of care initially dated October 30, 2024, revealed the resident had a series of falls and was at risk for injury Interventions included: use of a brightly colored call bell reminder sign, anti-rollback devices on the wheelchair, pre-bedtime toileting, rest period after dinner, therapy referrals, and application of Dycem (a thin, non-slip material) to the wheelchair. The care plan did not include documented interventions specifically addressing the resident's poor safety awareness, severe cognitive impairment, or repeated attempts to self-transfer. Progress notes revealed a repeated pattern of Resident 50 attempting to rise or transfer without staff assistance, despite her severely impaired cognition and known fall risk status. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of a progress note dated November 14, 2024, at 6:30 PM revealed the resident was sitting near the entrance of the TV area. Staff heard someone say, she's on the floor. Staff found the resident on the floor in front of her wheelchair with her back against the wall. The resident asked to go to bed. No injury was noted at that time. A progress note dated November 15, 2024, at 6:31 AM documented the resident attempted to rise without assistance. The note further described her gait as unsteady with one-person assistance during transfers. On November 16, 2024, at 7:05 PM, another progress note indicated the resident continued to attempt rising without assistance at times. A review of a progress note dated November 30, 2024, at 11:03 AM indicated the resident was observed in the process of self-transferring between bed and wheelchair. Staff noted that redirection efforts were ineffective due to her cognitive status. A review of a progress note dated December 7, 2024, at 3:11 AM revealed the resident was found sitting on the floor against the wall in her room. She had sustained skin tears to the left elbow, left upper arm, and left ring finger. A review of a progress note dated December 18, 2024, at 10:22 PM, revealed the resident was using the phone in her room. When she stood up to hang up the phone and then attempted to sit back down, she missed the chair and landed on her buttocks. Staff documentation indicated that the resident was re-educated on waiting for assistance, despite her severe cognitive impairment, which made such education ineffective as an intervention. On December 21, 2024, at 6:05 PM, staff were called to the resident's room and found her sitting on the floor with her wheelchair behind her and the bathroom door closed. Her roommate reported the resident had attempted to stand up and slid to the floor. The wheelchair brakes were not fully engaged at the time of the incident. Despite the repeated self-transfer attempts, the only new intervention added was the application of Dycem to the wheelchair. Between November 14 and December 25, 2024, multiple progress notes documented Resident 50 attempting to rise without assistance and engaging in unsafe self-transfer behaviors. Staff repeatedly documented the resident required redirection, which was often ineffective due to her cognitive status. Despite this pattern, the facility did not revise the plan of care to include additional supervision or more targeted interventions to prevent further falls. A review of a progress note dated December 25, 2024, at 7:38 AM, revealed at 6:50AM the resident was found lying on the floor at the head of the bed. She sustained two additional skin tears, which were treated with saline, Xeroform gauze (wound dressing), and a dry sterile dressing. Once again, staff documented the resident was educated on the use of her call bell, even though prior documentation repeatedly identified her as severely cognitively impaired and resistant to redirection. According to the investigative documentation provided by the facility the cause of this fall was due to the resident's self-transfer attempts. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Progress note on December 25, 2024, indicated later that same day, at 6:57 PM, staff were alerted by another resident and found Resident 50 lying face down on the floor, with blood above her right eyebrow and complaints of pain in the left shoulder and arm. She had been lying on her broken eyeglasses. The resident's roommate reported she had walked into the room and fell . The physician was notified, and new orders were obtained for stat (immediate) X-rays. A review of the facility provided investigative documentation identified the root cause as another unassisted attempt to ambulate and noncompliance with transfer assistance. A review of a progress note dated December 26, 2024, at 3:25 AM revealed the resident was medicated for complaints of pain to her left upper extremity. An X-ray performed the following morning, December 26, 2024, at 11:00 AM revealed that Resident 50 sustained a closed fracture of the left shoulder and wrist. She was transferred to the emergency department for further evaluation. Hospital records documented a traumatic subdural hemorrhage (a life-threatening collection of blood between the brain and its outer covering), a closed fracture of the distal end of left ulna (a break in the lower end of the ulna bone), a closed fracture of the left proximal humerus (a break in the upper arm bone), and lacerations of multiple sites (a wound caused by a tear or cut in the skin caused by trauma). The facility failed to implement enhanced interventions in response to the resident's ongoing fall attempts and did not reassess or revise the care plan to provide more frequent supervision, scheduled checks, or appropriate use of assistive technology such as bed or chair alarms. Furthermore, repeated re-education efforts were inappropriate for a resident with a severe cognitive deficit. An interview conducted with the Director of Nursing (DON) on May 29, 2025, at approximately 1:00 PM confirmed the facility failed to provide adequate supervision and implement appropriate fall prevention interventions based on the resident's assessed needs to prevent falls with injury. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51306 Based on observation, review of select facility policy and clinical records, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medications in one of two medication carts observed (Teal Hall). Findings include: Review of the facility policy titled Medication Labeling and Storage last reviewed by the facility February 13, 2025, indicated that multi-use vials that have been opened or accessed (e.g. needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. An observation of the medication cart located on Teal Hall unit on May 29, 2025, at 8:24 AM, in the presence of Employee 2 (Licensed Practical Nurse) of the medication stored in the medication cart, revealed two (2) multi-dose insulin pens of Insulin Lispro (a fast acting insulin medication used to lower blood sugar) and Insulin Glargine (a long acting insulin medication used to lower blood sugar) that had been opened and available for use, but not dated when initially opened. An interview with Employee 2 (LPN) on May 29,2025, at 8:24 AM, confirmed both multi dose insulin pens: Insulin Lispro and Insulin Glargine were opened, and available for use, and not dated when initially opened. Interview with the Nursing Home Administrator (NHA) on May 29,2025, at approximately 11:00 AM, confirmed the facility failed to adhere to acceptable storage and labeling practice for multi-dose medications. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48276 Based on observation, a review of facility-provided documents, and employee interviews, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination, including rodent activity, which increased the risk of food-borne illness in multiple areas of the kitchen. Findings include: According to the Centers for Disease Control (CDC), Controlling Wild Rodent Infestations, rodents can carry many diseases that can spread directly or indirectly to people, including through contact with rodent droppings, urine, or saliva. Signs of rodents include droppings (feces) and gnaw marks. The CDC indicates that to determine if the activity is current, regular cleaning and disinfecting are required. When droppings are identified following cleaning, it can confirm the presence of rodents. During an interview on May 28, 2025, the Director of Maintenance indicated the facility has an external pest management company that provides services to the building about once a month. The Director of Maintenance explained the pest management company has not reported any identification of rodent activity. The Director of Maintenance provided invoices for services rendered by the pest management company; however, a review of the invoices from December 2024 through May 2025 revealed the external company failed to identify any rodent activity. An observation on May 28, 2025, at 1:15 PM, revealed evidence of mouse activity in the facility's main dining room. Over 50 mouse-like droppings were seen on the floor in the resident main dining room underneath a cabinet running along the kitchen-side wall. During an observation on May 28, 2025, at 1:20 PM, active signs of mouse activity were noted in two areas of the kitchen. The dry storage area contained mouse-like droppings on the floor under metal storage racks. Also, in the corner of the meal preparation area of the kitchen, additional mouse-like droppings were identified scattered amongst silicone caulking pieces. The mouse-like droppings were found near a crevice in the wall, suggesting a potential entry point or an attempt by the mice to access the wall void. During an interview on May 30, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed the presence of mouse-like droppings in the facility's kitchen. The NHA confirmed it is the facility's responsibility to maintain acceptable practices for the storage and service of food to prevent the potential for contamination, including rodent activity, which increases the risk of food-borne illness. Refer F925 28 Pa. Code 201.18 (e)(2.1) Management.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48276 Based on observations, a review of facility-provided documents, and resident and employee interviews, it was determined the facility failed to maintain an effective pest control program, including observations made on one of the three nursing units (Grey Unit- bedrooms of Residents 4, 23, and 39), experiences reported by one resident out of 18 sampled (Resident 23), and experiences reported by two residents during a group interview (Residents 27 and 28). Findings include: According to the Centers for Disease Control (CDC), Controlling Wild Rodent Infestations, rodents can carry many diseases that can spread directly or indirectly to people, including through contact with rodent droppings, urine, or saliva. Signs of rodents include droppings (feces) and gnaw marks. The CDC indicates that to determine if the activity is current, regular cleaning and disinfecting are required. When droppings are identified following cleaning, it can confirm the presence of rodents. During an interview on May 28, 2025, the Director of Maintenance indicated the facility has an external pest management company that provides services to the building about once a month. The Director of Maintenance explained the pest management company has not reported any identification of rodent activity. The Director of Maintenance provided invoices for services rendered by the pest management company; however, a review of the invoices from December 2024 through May 2025 revealed the external company failed to identify any rodent activity. A review of facility-provided pest control invoices from December 2024 through May 2025 revealed no documented evidence of rodent or other pest activity. A facility tour and observations on May 28, 2025, revealed evidence of rodent activity in multiple resident rooms and common areas: An observation at 9:40 AM of Resident 39's bedroom revealed several mouse-like droppings (small, long, black pellets that were tapered at the ends- resembling a black grain of rice) on the floor in the window-side corner of the room. An observation at 12:38 PM of Resident 4's bedroom revealed over 20 mouse-like droppings in the window-side corner of the room. At the time of the observation, the Assistant Director of Nursing (ADON) confirmed the observation of the mouse-like droppings. An observation at 12:48 PM of Resident 23's bedroom revealed several mouse-like droppings on the floor, against the wall, and behind the window-side bed. An interview with Resident 23 at the same time as the observation revealed that he has seen mice a few times over the past few months running across the floor in his room. An observation on May 28, 2025, at 1:15 PM, revealed evidence of mouse activity in the facility's main dining room. Over 50 mouse-like droppings were seen on the floor in the resident main dining room underneath a cabinet running along the kitchen-side wall. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on May 28, 2025, at 1:20 PM, active signs of mouse activity were noted in two areas of the kitchen. The dry storage area contained mouse droppings on the floor under metal storage racks. In the corner of the kitchen, additional mouse-like droppings were identified scattered amongst silicone caulking pieces found near a crevice in the wall, suggesting a potential entry point or an attempt by the mice to access the wall void. During a resident group interview, two out of eight residents interviewed (Residents 27 and 28) indicated they observed rodents at the facility. Resident 27 recalled seeing a mouse last week in her bedroom. She explained she has been seeing the rodents for a few months and has reported it to staff. Resident 28 indicated that she saw mice a few months ago at the facility but has not had any recent experiences. During an interview on May 30, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed the facility had no documented evidence of an effective pest management program, including identification of mouse activity, specifically, mouse-like droppings in the facility kitchen, dining room, and multiple resident rooms. The NHA confirmed it is the facility's responsibility to maintain an effective pest control program to ensure the facility is free of rodents. Refer F812 28 Pa. Code 201.18 (e)(2.1) Management.