

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 03/27/2026
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)		
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** Based on clinical record review, observation, and resident and staff interviews, it was determined the facility failed to ensure one of 17 residents reviewed (Resident 8) was fully informed of, and participated in decision-making regarding, a restriction preventing the resident from using the bathroom connected to the bedroom. Findings include: Clinical record review revealed Resident 8 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic condition affecting the body's ability to regulate blood sugar) and above-the-knee amputation of the left leg (surgical removal of the leg above the knee joint). A review of Resident 8's admission Minimum Data Set (MDS, a federally required standardized assessment used to evaluate a resident's functional and cognitive status and assist with care planning) dated December 16, 2025, revealed Resident 8 was cognitively intact with a BIMS score of 14 (Brief Interview for Mental Status, a structured assessment of memory and orientation; scores of 13-15 indicate intact cognition). During an interview on March 25, 2026, at 11:00 AM, Resident 8 stated they were unaware why they were unable to use the bathroom connected to their bedroom to void (urinate). Resident 8 stated they would feel more comfortable using the bathroom in their room rather than being transferred to a commode (portable toilet) located in the shower room down the hall. Resident 8 indicated the only explanation provided was that the wheelchair would not fit through the bathroom doorway. An interview with Resident 8 on March 25, 2026, at 11:00 AM, revealed that Resident 8 was unaware of why they were unable to use the bathroom connected to their bedroom to void (urinate). Resident 8 stated they would feel more comfortable using the bathroom in their room rather than being transferred to a commode (portable toilet) located in the shower room down the hall. Resident 8 indicated the only explanation provided was that the wheelchair would not fit through the bathroom doorway. Observation on March 25, 2026, at 11:00 AM revealed Resident 8's wheelchair was able to fit through the doorway connecting the bedroom to the bathroom and was not inhibiting them from entering the bathroom. Review of Resident 8's clinical record and most recent care plan dated December 16, 2025, failed to include documentation that the resident was informed of the reason for the restriction, the risks or safety concerns associated with bathroom use, alternative options considered, expected duration of the intervention, or plans for reassessment of the resident's ability to use the bathroom in their room. Documentation also failed to reflect the resident's understanding of the restriction or the resident's preferences regarding this intervention. During an interview on March 26, 2026, at 10:30 AM, Employee 1, an occupational therapist (OT) stated the resident's bathroom did not allow adequate space for certain transfer equipment (devices used to assist a person in safely moving from one surface to another). Employee 1 OT stated the shower room provided additional space to assist the resident on and off the commode. During an interview on March 26, 2026, at 11:00 AM, Employee 1 OT and the Director of Nursing (DON) were unable to provide documentation that Resident 8 was fully informed of the reason for the restriction, the anticipated duration of the intervention, potential alternatives, or any plan to reassess the resident's ability to safely use the bathroom connected to their bedroom. Documentation also failed to demonstrate the resident's participation in the decision-making process or confirmation of resident understanding. 28 Pa. Code 201.29(4) Resident rights. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395905
		If continuation sheet Page 1 of 8

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, admission documentation, and staff interview, it was determined the facility failed to provide and maintain required written admission information and documentation for one of 17 residents reviewed (Resident 63). Findings include: Review of the facility policy titled Admissions Policy, last reviewed February 24, 2026, indicated the facility will admit only those individuals whose clinical (medical), physical (body function and mobility), psychosocial (mental health and social well-being), and emotional needs can be met by the facility. Review of the facility admission Agreement revealed the agreement included services, charges and fees, termination of the agreement, and miscellaneous areas to be reviewed with each newly admitted resident and/or resident representative. The admission Agreement included an admission Agreement signature page. Clinical record review revealed Resident 63 was admitted to the facility on [DATE], with diagnoses that included cervical myelopathy (compression of the spinal cord in the neck which may cause pain, weakness, or difficulty with movement) and generalized muscle weakness (reduced muscle strength). Resident 63 was discharged from the facility on February 21, 2026. Review of Resident 63's admission Minimum Data Set assessment (MDS, a federally required standardized assessment used to evaluate resident needs and develop a plan of care) dated January 5, 2026, revealed Resident 63 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a structured cognitive screening tool used to assess memory and orientation; a score of 13-15 indicates intact cognition). Documentation indicated that the resident and resident representative participated in the assessment process. Review of Resident 63's clinical record, including social service documentation and communication with the resident's family, failed to include documented evidence that required admission information was provided and acknowledged at the time of admission. Documentation did not include evidence the resident and/or resident representative received written information regarding patient portion liability (the amount the resident is responsible to pay), daily rate cost structure, resident rights, appeal rights (the right to formally dispute decisions regarding care or services), consent to treatment (permission allowing the facility to provide care), the right to choose ancillary services (services such as therapy providers or pharmacy), bed hold policy (a policy describing whether the facility will hold a resident's bed during hospitalization and any associated cost), or consequences for failure to pay. During an interview on March 27, 2026, at 9:30 AM the Nursing Home Administrator (NHA) confirmed that admission paperwork is to be reviewed with each resident and/or resident representative upon admission to the facility. The NHA failed to provide documented evidence that admission paperwork was completed as required for Resident 63. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.5 (f)(i)(xi) Medical records. 28 Pa. Code 211.10 (c)(d) Resident care policies		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to ensure licensed nurses accurately administered prescribed medication consistent with professional standards of practice for one of five residents sampled for unnecessary medications (Resident 1). Findings include: 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 carry out nursing care actions that promote, maintain, and restore the well-being of individuals. 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. Review of the facility policy titled General Dose Preparation and Medication Administration last reviewed by the facility on February 24, 2026, revealed that prior to administration of medication facility staff should take all measures required by facility policy and applicable law, including verify each time a medication is administered that it is at the correct dose (amount of medication given), correct route (how the medication enters the body, such as by mouth), correct rate (how fast the medication is given, when applicable), correct time, and for the correct resident. The policy indicated staff should obtain vital signs (measurements of basic body functions such as blood pressure, pulse, breathing rate, and temperature) when required by the medication order. A clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and chronic combined systolic (phase when the heart squeezes) and diastolic (phase when the heart relaxes) congestive heart failure (heart muscle is both too weak to pump effectively and fill properly leading to inability to meet the body's oxygen needs, causing fluid congestion in the lungs and body). Review of a physician's order dated February 7, 2026, revealed an order for Midodrine (medication used to treat low blood pressure) 5 mg one tablet by mouth for systolic blood pressure (top number in a blood pressure reading) less than 100 mm/Hg (milliliters of mercury) three times per day as needed. Review of the Medication Administration Record (MAR) for February 2, 2026, through February 28, 2026, and March 1, 2026, through March 25, 2026, revealed Midodrine was not administered on four occasions when the resident's systolic blood pressure was below 100 mm/Hg, as evidenced by the following documented blood pressure readings: February 10, 2026, 1:35 PM BP 98/60 mm/Hg February 28, 2026, 4:48 PM BP 99/71 mm/Hg March 1, 2026, 11:49 AM BP 97/65 mm/Hg March 2, 2026, 10:50 AM BP 98/66 mm/Hg These medication omissions occurred despite the physician's explicit parameters to administer the medication for a systolic reading of less than 100 mm/Hg. During an interview on March 26, 2026, at 11:00 AM, the assistant director of nursing (ADON) acknowledged that nursing staff did not follow acceptable standards of nursing practice related to medication administration. The ADON confirmed medications are to be administered as prescribed, in a safe and timely manner, and in accordance with physician orders. 28 Pa. Code 211.5(f)(ii)(ix) Medical records. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, select facility policy review, and staff interview it was determined the facility failed to consistently ensure the provision of respiratory care and supplemental oxygen in accordance with physician orders and facility policy for one resident out of 17 residents reviewed. (Resident 65) Findings included: A review of the facility policy titled Oxygen Administration (all routes) last reviewed by the facility on February 24, 2026, indicated that licensed clinicians with demonstrated competence are responsible for administering oxygen via the ordered route. The policy further requires staff to monitor oxygen delivery systems, including checking oxygen cylinder (oxygen tanks which contain oxygen under pressure) gauges to ensure an adequate oxygen supply is available to meet the residents' needs. During an initial facility tour of the facility on March 24, 2026, at 12:12 PM, Resident 65 was observed seated in a wheelchair in the main dining room with an oxygen tank attached to the back of the wheelchair. The oxygen tank gauge indicated the tank was empty. This observation was confirmed by the Director of Nursing (DON). Review of the clinical record revealed Resident 65 was admitted to the facility on [DATE], with diagnoses including respiratory failure with hypoxia (not enough oxygen passes from the lungs to the blood, making it difficult to breath), centrilobular emphysema (type of chronic obstructive pulmonary disease characterized by the destruction of air sacs in the center of the lung nodule, causing shortness of breath, coughing, and reduced oxygen exchange), and pneumothorax (collapsed lung). A physician's order dated March 19, 2026, specified oxygen at 3 liters/minute via nasal cannula (flexible plastic tubing with small prongs inserted into the nostrils to deliver supplemental oxygen), to be administered continuously. Review of the admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 24, 2026, indicated the resident 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 represents severe cognitive impairment) and required extensive assistance from staff for activities of daily living, bed mobility, and transfers, indicating reliance on staff to ensure ordered treatments were implemented. An observation conducted on March 25, 2026, at 9:45 AM, revealed Resident 65 lying in bed on the left side, asleep, without oxygen in use. The oxygen concentrator (bedside machine that concentrates ambient air to supply an oxygen-rich gas stream) and nasal cannula were observed 3.5 feet away from the resident, with the oxygen tubing and nasal canula lying directly on the floor and not in use. This observation was confirmed by Employee 2 Licensed Practical Nurse (LPN). The facility failed to ensure consistent delivery and monitoring of physician ordered oxygen therapy, failed to maintain oxygen equipment in a ready-to-use state, and failed to follow facility policy for oxygen administration. During an interview on March 26, 2026, at 10:45 AM, the DON revealed the facility was unable to provide documentation identifying the frequency of monitoring oxygen tanks. The DON acknowledged that the facility failed to ensure oxygen therapy was administered as ordered for Resident 65. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident Policies.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select policy review, and staff and resident interview, it was determined the facility failed to ensure the timely acquisition and availability of prescribed medications for one of 20 residents reviewed (Resident 7). Findings include: Clinical record review revealed that Resident 7 was admitted to the facility on [DATE], with diagnosis to include (a chronic medical condition in which the body cannot properly regulate blood sugar levels) and required injectable medication to maintain acceptable blood glucose levels. A review of Resident 7's quarterly Minimum Data Set assessment, (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 2, 2026, revealed that Resident 7 was cognitively intact with a BIMS score of 14, (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 through 15 indicates the resident is cognitively intact). Review of physician orders for March 2026 revealed Resident 7 was prescribed degludec (a long-acting insulin used to control blood sugar levels) to be administered nightly at 9:00 PM. Review of the facility policy titled Emergency Deliveries, dated February 24, 2026, revealed the facility is to immediately notify the pharmacy when a physician order requires emergency medication delivery to ensure medications are available for administration as prescribed. Review of the Medication Administration Record (MAR) dated March 17, 2026, at 9:00 PM and a nurse's note dated March 18, 2026, at 3:07 AM revealed the ordered degludec insulin was not available for administration at the scheduled time of 9:00 PM on March 17, 2026. Documentation indicated the medication was not administered until 3:00 AM on March 18, 2026. At that time, Resident 7's blood glucose level measured 346 mg/dL (milligrams per deciliter, a unit used to measure the amount of sugar in the blood; normal fasting levels are generally 70-120 mg/dL), indicating significantly elevated blood sugar levels. During an interview on March 26, 2026, at 9:30 AM, Resident 7 confirmed the ordered insulin was not available at the scheduled time and reported staff awakened him during the early morning hours (in the middle of the night) to administer the injection. During an interview on March 27, 2026, at 9:30 AM, the Director of Nursing (DON) confirmed the facility had sent notifications to the pharmacy requesting the prescribed degludec insulin on March 16, 2026, at 10:27 PM and March 17, 2026, at 6:25 PM prior to depletion of the medication supply for Resident 7. There was no documented evidence the facility ensured the medication was obtained and available for administration as ordered. 28 PA. Code 211.10 (c)(d) Resident care policies. 28 PA. Code 211.12(c)(d)(1)(3)(5) Nursing services.		

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, resident interview, staff interview, and review of facility practices, it was determined the facility failed to ensure effective management and execution of the duties and responsibilities of the food and nutrition services department to provide timely meal service for three of 17 residents reviewed (Residents 66, 23, and 8). Findings include: Observation during the breakfast meal on March 25, 2026, at 8:05 AM revealed Resident 66's roommate was eating breakfast in their semi-private room (a room shared by two residents). Interview with Resident 66, who was alert and oriented (able to understand and respond appropriately), at that time revealed she had not received her breakfast meal tray despite her roommate receiving a tray. Resident 66 confirmed she prefers to eat meals in her room and does not attend the dining room. Observation of the food cart located in the hallway outside Resident 66's room revealed the resident's breakfast tray was not present on the cart. Interview with Employee 3 NA (nurse aide) on March 25, 2026, at 8:10 AM confirmed she delivered a breakfast tray to Resident 66's roommate but did not see a tray for Resident 66. Employee 3 NA indicated that meal trays are not always placed on the cart in room number order. The Food Service Director (FSD) arrived at the nursing unit at that time and confirmed Resident 66's meal tray should have been present on the food delivery cart designated for the resident's room number. The FSD returned to the food and nutrition services department to have a breakfast meal prepared and delivered to Resident 66. Resident 66 received her breakfast tray at 8:15 AM. During a resident group interview conducted on March 25, 2026, at 10:00 AM, Residents 23 and Resident 8 reported they have experienced missed meal trays. Resident 23 stated the missed tray happened just last week, and Resident 8 stated missed trays occur once in a while. Both residents reported that when they notify nursing staff, the food and nutrition services department sends a tray. Interview with the FSD on March 26, 2026, at 8:15 AM confirmed that a meal ticket (printed document generated from the computerized meal tray program identifying each resident's ordered diet and meal) is printed for each resident for every meal to ensure each resident receives the correct diet as ordered. The FSD confirmed meal tickets are counted prior to meal service to ensure a ticket is present for each resident. The FSD confirmed Resident 66's breakfast tray was delayed on March 25, 2026, due to a missing meal ticket. The FSD indicated that when staff notify the food and nutrition services department that a resident did not receive a tray, a meal is prepared according to the ordered diet and delivered to the nursing unit. Interview with the Nursing Home Administrator on March 26, 2026, at 10:00 AM confirmed meal trays are expected to be delivered in a timely manner, and a meal ticket is to be printed for each resident at each meal to ensure meal service accuracy and timeliness. The facility failed to effectively manage the food and nutrition services department to ensure a meal ticket was generated for Resident 66, resulting in delayed delivery of the resident's breakfast meal on March 25, 2026. The facility also failed to ensure consistent systems were in place to prevent missed meal trays as reported by Residents 23 and 8. 28 Pa. Code 201.18 (b)(3)(e)(3)(6) Management.		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, select facility policy review, and staff and family interviews, it was determined that the facility failed to provide and ensure implementation of specialized rehabilitative services in accordance with professional standards of practice for positioning assessment, intervention, care planning, and staff training for 1 of 17 residents reviewed (Resident 12). Findings include: Review of the facility policy titled Seating and Positioning Program last reviewed by the facility on February 24, 2026, indicated that positioning is a cooperative effort between nursing and therapy services. Evaluation of the resident with recommendations for positioning is the responsibility of the Occupational and/or Physical Therapy Department under a physician's order. Development of the positioning program and provision of positioning aids is the responsibility of the Physical (PT) and Occupational Therapy (OT) Departments. Upon completion of the positioning program and provision of the positioning aids, nursing carries out the positioning program. In-services for specific positioning techniques, use of positioning aide, and positioning schedule will be provided by therapies in cooperation with nursing. Upon completion of the in-services, the program will become the responsibility of nursing. The Therapy Department will also provide instructions in positioning to nursing assistants, nursing staff and other caregivers within the facility. The policy indicated that it is the primary responsibility of the OT or PT with input from the interdisciplinary care team as needed, to determine the need for positioning interventions. It is the responsibility of OT/PT department to order resident positioning aids and to add the appropriate documentation to the resident's care plan throughout their intervention. Prior to nursing providing positioning, unit staff and/or restorative staff will be in-serviced on the positioning program/device and schedule. Therapy will train these staff members to adequately conduct return demonstrations. During an initial facility tour of the facility on March 24, 2026, at 11:55 AM, Resident 12 was observed seated in a Broda chair (a specialized wheelchair with a flexible frame that allows reclining and tilting for positioning and comfort) in the activity room with the chair reclined. The resident exhibited significant left lateral flexion of the neck and trunk (abnormal bending of the head and body toward one side), with the left ear strongly tilted toward the left shoulder. No cervical positioning device (equipment used to support proper head and neck alignment) or visible trunk support was in place. At 12:20 PM on the same day, Resident 12 was observed being fed by his sister, who had applied a neck pillow (a U-shaped cushion designed to support the head and neck). Interview with the resident's sister revealed she independently provided the neck pillow due to concerns related to worsening head positioning and its impact on swallowing. The resident's sister indicated the facility had not provided appropriate cervical support and reported positioning devices were often not in place during visits. Clinical record review revealed Resident 12 was admitted [DATE], with diagnoses including Parkinson's disease (a disorder of the nervous system that affects movement, commonly causing tremors, stiffness, and slowed movement) and neurocognitive disorder with Lewy bodies (a progressive type of dementia characterized by cognitive decline, changes in alertness, visual hallucinations, and movement problems similar to Parkinson's disease). Review of the quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 19, 2026, indicated Resident 12's BIMS interview (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) was not completed, which indicated that the resident was unable to provide or did not provide answers to complete this section. The MDS indicated that the resident was dependent on staff for all activities of daily living (routine daily care tasks such as transferring, repositioning, and mobility), including positioning. Review of physician orders revealed no orders for positioning devices to address cervical alignment needs. Review of Resident 12's comprehensive care plan dated February (continued on next page)		

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	25, 2026, identified impaired positioning and included interventions related to armrest cushions and invert bilateral upper wing support (placing cushions upside down on the upper side supports of the Broda chair). The care plan lacked clear, measurable, and individualized instructions and did not address the resident's cervical contracture (permanent tightening of muscles resulting in abnormal positioning) or include specific interventions to maintain proper head and neck alignment. Review of the Occupational Therapy Evaluation dated February 24, 2026, indicated the reason for referral was poor positioning in the Broda chair. The evaluation indicated that the resident exhibited a left lateral neck contracture (no measurements documented), that the contracture affected his functional skills, and that skilled therapy was needed to address this impairment. Clinical impressions from the evaluation indicated the resident displayed a left lateral neck contracture as well as curvature resulting in the right side of his torso pressing against the side of the Broda chair with his left upper extremity hanging over the left side of the chair. OT was recommended to reduce the risk for development of wounds. Goals included the use of adaptive equipment/devices to achieve midline position while sitting in the wheelchair. Review of the Occupational Therapy Discharge summary dated [DATE], indicated the resident achieved the short-term goal of maintaining midline positioning while seated using adaptive equipment for greater than eight hours. Interventions included trial of alternative wheelchair cushions and supports and training of staff and caregivers in positioning techniques. The discharge summary failed to identify the specific positioning devices or modifications required for continued implementation of the positioning program. Review of therapy documentation revealed no evidence staff received training regarding positioning techniques, devices, or schedules as required by facility policy. Observation on March 25, 2026, at 8:25 AM and again at 8:40 AM revealed Resident 12 seated in common areas with unsupported left lateral trunk and cervical positioning. The Broda chair lateral supports were not positioned as identified in the care plan. Interviews with multiple staff, including the Nursing Home Administrator and Physical Therapist, revealed staff were unable to explain or demonstrate the care plan intervention described as invert bilateral upper wing support. During an interview on March 25, 2026, at 2:40 PM, the Director of Rehabilitation confirmed cervical positioning devices were not identified in the discharge summary and confirmed staff training regarding positioning interventions and devices had not been documented. The Director of Rehabilitation further confirmed the resident's family provided the neck pillow. The facility failed to ensure therapy-identified positioning needs were translated into clearly defined and individualized care plan interventions, failed to ensure specialized rehabilitative services recommendations were implemented following therapy discharge, and failed to ensure staff were trained and competent to carry out the positioning program as evidenced by observations of the resident without appropriate support to maintain functional body alignment necessary to support safe swallowing, comfort, and prevention of complications associated with abnormal positioning. 28 Pa. Code 211.12 (d)(5) Nursing services.28 Pa. Code 211.10 (c)(d) Resident care policies.		