STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395905	A. BLDG: 00 B. WING:	02/13/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
THIRD AVENUE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **068502**	**702 THIRD AVENUE** **KINGSTON, PA 18704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Findings of an abbreviated complaint survey completed on February 13, 2025, at Third Avenue Health and Rehab Center it was determined there were no federal deficiencies, related to the Health portion of the survey process, identified under the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care as they relate to the Health portion of the survey process; however, the facility was not in compliance with 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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P 5520	Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	Step 1. The facility cannot retroactively provide the minimum number of Nurse Aide hours for cited dates. Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated Nurse Aide ratio hours. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios. Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of Nurse Aide for the facility. Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum Nurse Aide hours needed for the facility. Audits will be completed 5x/ week x4 weeks, and then weekly x2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/25/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
THIRD AVENUE HEALTH & REHAB CENTER STATE LICENSE NUMBER: 068502	702 THIRD AVENUE KINGSTON, PA 18704

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P 5520	Continued from page 1 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 9 shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. January 30, 2025 - 4.33 nurse aides on the evening shift, versus the required 4.36 for a census of 48. January 30, 2025 - 2.97 nurse aides on the night shift, versus the required 3.2 for a	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 2 census of 48. January 31, 2025 - 4.13 nurse aides on the day shift, versus the required 4.80 for a census of 48. January 31, 2025 - 4.27 nurse aides on the evening shift, versus the required 4.36 for a census of 48. January 31, 2025 - 3.13 nurse aides on the evening shift, versus the required 3.20 for a census of 48. February 1, 2025 - 4.6 nurse aides on the day shift, versus the required 4.7 for a census of 47. February 3, 2025 - 3.9 nurse aides on the evening shift, versus the required 4.27 for a census of 47. February 3, 2025 - 3 nurse aides on the night shift, versus the required 3.13 for a census of 47. February 4, 2025 - 2.97 nurse aides on the night shift, versus the required 3.27 for a	P 5520		

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P 5520	Continued from page 3 census of 49. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on February 13, 2025, at approximately 2:15 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 4 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	Step 1. The facility cannot retroactively provide the minimum number of LPN hours for cited dates. Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated LPN ratio hours. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios. Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of LPNs for the facility. Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum LPN hours needed for the facility. Audits will be completed 5x/ week x4 weeks, and then weekly x2 months. The results of the audits will be forwarded to the facility QAPI	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/25/2025**

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P 5530	Continued from page 5	P 5530	committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 6 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for 7 shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:40 on the night shift based on the facility's census. January 30, 2025 - 1 LPNs on the night shift, versus the required 1.2 for a census of 48. January 31, 2025 - 1 LPNs on the night shift, versus the required 1.2 for a census	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 of 48. February 1, 2025 - 1.56 LPNs on the evening shift, versus the required 1.57 for a census of 47. February 1, 2025 - 1 LPNs on the night shift, versus the required 1.18 for a census of 47. February 2, 2025 - 1 LPNs on the night shift, versus the required 1.5 for a census of 46. February 3, 2025 - .97 LPNs on the night shift, versus the required 1.18 for a census of 47. February 4, 2025 - 1.06 LPNs on the night shift, versus the required 1.23 for a census of 49. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5530		

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P 5530	Continued from page 8 An interview with the Director of Nursing on February 13, 2025, approximately 2:15 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 9 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	Step 1. The facility cannot retroactively correct the past nursing hour PPD. Step 2. Moving forward, the facility will continue to schedule staff to meet or exceed the mandated PPD requirement of 3.20. The facility will make all good-faith efforts to utilize both internal and external resources to meet or exceed the staffing ratios. Step 3. To prevent this from reoccurring, the RDCS/designee reeducated the NHA, DON and Scheduler on the updated staffing regulations in relation to the minimum staffing of 3.20 hour PPD. Step 4. To monitor and maintain ongoing compliance, the NHA/designee will audit deployment sheets to ensure the facility staffing meets or exceeds the minimum 3.20 hours PPD. Audits will be completed 5x/ week x4 weeks, and then weekly x2 months. The results of the audits will be forwarded to the facility QAPI committee for further review and	Completion Date: **03/04/2025** Status: **APPROVED** Date: **02/25/2025**

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P 5640	Continued from page 10	P 5640	recommendations.	

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P 5640	Continued from page 11 Based on a review of nurse staffing, resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily. Findings include: A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident: January 31, 2025 - 3.12 direct care nursing hours per resident. February 1, 2025 - 2.90 direct care nursing hours per resident. The facility's general nursing hours were below minimum required levels on the dates noted above. An interview with the Director of Nursing on February 13, 2025, at approximately 2:15 PM confirmed the facility failed to consistently provide	P 5640		

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P 5640	Continued from page 12 minimum general nursing care hours to each resident.	P 5640		

Certified End Page

THIRD AVENUE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 068502

SURVEY EXIT DATE: 02/13/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY