STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395397	A. Building B. Wing	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Rehabilitation and Nursing Center	200 Second Avenue Kingston, PA 18704

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26861 Based on a review clinical records and staff interview it was determined that the facility failed to develop and implement an effective discharge planning process to ensure an individualized discharge plan was developed to meet the post-discharge needs of one resident discharged from the facility for one out of 12 residents(Resident CR1). Findings Include: A review of the clinical record revealed that Resident CR1 was admitted to the facility on [DATE], and discharged [DATE]. A review of an admission MDS (Minimum Data Set Assessment) dated May 23, 2021, section Q0400 Discharge Planning, indicated that the resident's goal was to return to the community. A review of the resident's comprehensive care plan revealed that the resident's care plan failed to include the resident's goal to return to the community and interventions for a safe and orderly discharge from the facility. A review of the discharge instruction form dated August 12, 2021, submitted by the facility during the survey ending August 17, 2021, revealed that the resident had reportedly been provided with instructions to include the name and contact number of a home health agency along with names and contact numbers for community resources. However, there was no indication that these discharge recommendations and/or instructions had been implemented upon the resident's discharge. The discharge instruction form was not signed by the resident or the resident's representative acknowledging receipt and awareness of the instructions. During an interview with the Nursing Home Administrator (NHA) and the facility's Corporate Nurse on August 17, 2021, at 4:40 PM, it was confirmed no evidence that the resident and/or representative had signed the discharge form to verify the instructions had been provided and reviewed with the resident and no evidence of the development and implementation of an individualized discharge plan for this resident. Refer F745 28 Pa. Code 201.25 Discharge policy

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 0684 Level of Harm - 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** 26142 Based on a review of clinical records and staff interview it was determined that the facility failed to follow physician orders for bowel protocol for two residents out of 12 sampled (Resident A1, A 2). Findings include: Review of the physician ordered bowel protocol indicated that both Residents A1 and A2, were prescribed Milk of Magnesia Suspension 1200 MG/15 ML (Magnesium Hydroxide, a laxative) Give 1 Tbsp by mouth as needed for constipation on second shift of day 3 no BM, Dulcolax Suppository 10 MG, Insert 1 suppository rectally as needed for constipation given on 1st shift of day 4 no BM and Fleet Enema Enema 7-19 GM/118 ML (Sodium Phosphates), Insert 1 application rectally as needed for constipation give on 1st shift on day 5 of no BM. A review of the clinical record revealed that Resident A1 was admitted to the facility on July, 2019, with diagnoses including hypertension and anxiety. Review of Resident A1's report of bowel activity from August 10, 2021, to August 15, 2021, revealed that the resident did not have a bowel movement during that time period. Review of Resident A1's Medication Administration Record (MAR) for August 2021 through the survey ending August 17, 2021, revealed no documented evidence that the facility administered the resident's prescribed bowel protocol during this period without a bowel movement. A review of the clinical record revealed that Resident A2 was admitted to the facility on [DATE], with diagnoses including hypertension and anxiety. Review of Resident A2's report of bowel activity from August 10, 2021, to August 13, 2021, revealed that the resident did not have a bowel movement during this time period. Review of Resident A1's Medication Administration Record (MAR) for August 2021 through the survey ending August 17, 2021, revealed that licensed nursing staff did not follow the physician ordered bowel protocol as ordered during this period without bowel activity. Interview with the assistant Director of Nursing on August 17, 2021 at p.m. confirmed that there was no documented evidence that physician ordered bowel protocol was followed for the above residents. 28 Pa. Code 211.12 (a)(d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f)(g)(h) Clinical records.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 21738 Based on a review of clinical records and select facility incident reports and staff interview it was determined that the facility failed to maintain an environment free of potential accident hazards and failed to carry planned supervision to promote the safety of one resident and failed to plan interventions to promote the safety of one resident out of 8 residents reviewed (Resident B3 and Resident A5). Findings include: A review of the clinical record revealed that Resident B3 had diagnoses, which included a history of alcohol abuse and depression. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 23, 2021, revealed that the resident had a BIMS (brief interview mental screening for mental status) score of 15 (a score of 13-15 indicates cognitively intact). Review of a resident incident report dated August 3, 2021, at 7:32 PM noted that staff observed that the resident had hand sanitizer hidden in his room and another on the table in his room. The hand sanitizer was removed and the CRNP was notified. A physician order for STAT (immediate) labs, CBC (complete blood count), and CMP (comprehensive metabolic panel) were ordered and to provide 1:1 supervision (staff is to be assigned to supervise resident at all times) was ordered. Review of an incident report dated August 5, 2021, at 8:50 AM revealed that the resident was found in his room with legs extended forward on the floor between the beds with his back toward the door. The resident's wheelchair was in front of the television facing between beds. The resident was actively bleeding from an area on the forehead, measuring 1 inch length x 0.2 cm in width. Pressure was applied immediately. The area was cleansed and a pressure bandage was applied. Also noted to left forehead was a bump measuring 2 inches by 2 inches and bruised. Review of the resident description of the incident noted that the resident stated at the time of the incident that he felt like he was falling and grabbed the bed. The resident stated that he was already laying in the bed and fell out. Interventions in place at the time of the resident's fall from bed were noted as the resident had non-skid socks on at the time of the incident. There was no indication that the resident was on 1:1 supervision as ordered by the physician on August 3, 2021, when the resident fell from bed on August 5, 2021. The CRNP was notified, and an order was given to transfer the resident to the emergency room for evaluation and treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the emergency room discharge date d August 5, 2021 at 3:26 PM noted the resident was evaluated for a fall and the laceration (to his head) was repaired with adhesive glue. CAT scans were negative. A nurses note dated, August 5, 2021 at 5:34 PM noted the resident returned from the hospital. The resident was placed on 1:1 supervision with staff member. An interview with the chief nursing officer on August 17, 2021 at approximately 3:00 PM confirmed that the physician ordered 1:1 supervision was not implemented as ordered to prevent the resident's fall and maintain an environment free of potential accident hazards. A review of the clinical record revealed that Resident A5 was admitted to the facility on [DATE], with diagnoses that include status post fracture with therapy services and profound intellectual disability. A review of the resident's care plan dated May 13, 2021, revealed the goal that the facility will meet the resident's physical, mental and psychosocial needs. The resident's plan of care noted that the resident has profound, intellectual disability and staff were to assist the resident in all aspects of care. A review of a quarterly Minimum Data Set (MDS) assessment (a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated June 24, 2021, revealed that the resident had severe cognitive impairment, required maximum staff assistance for all activities of daily living and utilized a wheelchair for ambulation. A review of a facility incident investigation and nursing documentation dated August 1, 2021, at 11:59 AM revealed Resident A5 was found at the start of the shift, seated on the floor mats next to her bed in her room. Nursing noted that the resident had a bruise under her left eye measuring 1 cm x 1 cm with no swelling noted. Resident A5 was unable to state if she had any pain or discomfort. She was unable to give a description of the incident or how she sustained the injury. The facility obtained no witness statements as part of an investigation into the resident's incident or injury. The Nurse Practioner was made aware. No new orders received. RN supervisor made aware. Resident representative was called and notified. A review of nursing documentation dated August 2, 2021 at 2:03 PM revealed that the resident was in the broda chair (a low to the ground wheelchair which allows the residents feet to propel the chair) self propelling in hall and the bruise persisted under left eye A review of a nurse's note dated August 3, 2021, at 2:41 PM revealed call placed to RN nurse practioner for facial xray re: bruise under left eye. X ray ordered for today. A review of a facial X-ray dated August 3, 2021, revealed There is mild irregularity in contour of the tip of the nasal bone, which could be related to residuals of acute or chronic fracture and clinical correlation is needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence at the time of the survey August 17, 2021, that the facility had thoroughly investigated the resident's incident and injury to plan preventative care accordingly to prevent similar incidents and injury to this resident with a profound intellectuality disability. Nursing noted that the resident self-propels in the wheelchair, but there was no documented evidence that the resident, who lacks safety awareness, planned and provided sufficient supervision of the resident. During an interview with the Director of Nursing on August 17, 2021 at 3 PM, she acknowledged that there was no documented evidence that the facility was actively addressing Resident A5's needs related to the resident's intellectual disability to meet the resident's to promote the resident's safety and well-being. 28 Pa. Code 211.12 (a)(d)(1)(3)(5) Nursing services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 21738 Based on observations, review of clinical records and staff interview it was determined that the facility failed to provide necessary care to prevent complications for two residents receiving an enteral tube feeding out of three sampled residents (Residents B1 and B2). Findings include: A review of the clinical record revealed that Resident B1 had a current physician order for Glucerna 1.2 at 50 cc/hr, to start at 7:00 PM and run until 600 ml infused and 30 ml water flush via PEG (percutaneous endoscopic gastrostomy tube- tube placed into the stomach to provide nutrition) per hour. The resident was also prescribed a pureed diet by mouth. An observation on August 17, 2021, at 11:00 AM revealed a piston syringe in a plastic bag, which was not dated hanging on the tube feeding pole located next to the resident's bed. There was also a container with 150 ml water (for flushes) located on the resident's nightstand which was not dated. Interview with employee 1 (LPN) at this time that the piston syringe and container of water were to be dated. Employee 1 confirmed that tube feeding supplies were to be properly maintained and not to be left on the resident's nightstand. A review of the clinical record revealed that Resident B2 had a current physician order for Jevity 1.5 at 75 cc/hr start at 2:00 PM and run until 1500 ml infused and 60 ml water flush via PEG per hour. An observation on August 17, 2021 at 11:15 AM revealed a piston syringe in a plastic bag, which was not dated hanging on the tube feeding pole located next to the resident's bed. During an interview August 17, 2021 at 12:00 PM the Chief Nursing Officer confirmed that tube feeding supplies were to be dated and properly maintained to prevent complications with enteral tube feedings. 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of employee job descriptions and clinical records and interviews with staff it was determined that the facility failed to provide medically related social services, including assistance with obtaining any needed services from outside entities for transitions of care services for returning to home, for one resident out of 12 sampled (Resident CR1) Findings included: The facility job description for the Social Services Director indicated that the social services department acts as a role model in matters of protecting and promoting resident rights. Social services will record progress notes in the clinical record and evaluates facility residents for discharge potential. Provide discharge planning services when discharge is anticipated. Provides information about community resources and provides discharge summary for resident's record, with consent of resident, for release of authorized persons and agencies. A review of the clinical record revealed that Resident CR1 was admitted to the facility on [DATE] and discharged on [DATE]. A review of an admission MDS (Minimum Data Set Assessment) dated May 23, 2021, section Q0400 Discharge Planning, indicated that the resident's goal was to return to the community. A review of the resident's comprehensive care plan revealed that the resident's care plan failed to include the resident's goal to return to the community and interventions for a safe and orderly discharge from the facility. A review of the discharge instruction form dated August 12, 2021, submitted by the facility during the survey ending August 17, 2021, revealed that the resident had reportedly been provided with instructions to include the name and contact number of a home health agency along with names and contact numbers for community resources. However, there was no indication that these discharge recommendations and/or instructions had been implemented upon the resident's discharge. The discharge instruction form was not signed by the resident or the resident's representative acknowledging receipt and awareness of the instructions. During an interview with the Nursing Home Administrator (NHA) and the facility's Corporate Nurse on August 17, 2021, at 4:40 PM, it was confirmed no evidence that the resident and/or representative had signed the discharge form to verify the instructions had been provided and reviewed with the resident and no evidence of the development and implementation of an individualized discharge plan for this resident. A review of the resident's clinical record conducted during the survey ending August 17, 2021, revealed no documented evidence that social services staff had visited and/or provided social services, including discharge planning, to the resident during her stay at the facility from May 18, 2021, through her discharge of August 16, 2021. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the discharge instruction form, submitted by the facility during the survey of August 17, 2021, and dated August 12, 2021, indicated that the resident was to be discharged with referrals services in place on discharge date . However, there was no documented evidence that social services had implemented the discharge referral recommendations and the form was not signed by the resident or representative. During an interview with the Nursing Home Administrator (NHA) and the facility's Corporate Nurse on August 17, 2021, at 4:40 PM, it was confirmed, there was no social service notes in the clinical record for the entirety of the resident's admission to the facility. There was no evidence that discharge instructions were provided to the resident prior to, or upon her discharge. The NHA confirmed that there was no evidence of the provision of medically related social services to the resident, including evidence of that the social service director had coordinated the resident's discharge planning and provided instructions to the resident as per the employee's job description. Refer F 660 28 Pa. Code: 201.18(b)(1)(2)(e)(1) Management 28 Pa. Code: 211.16(a) Social services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and staff interviews, it was revealed that the facility failed to ensure that residents were free of significant medication errors for two of 12 residents reviewed (Resident A3 and A4). Findings include: Clinical record revealed that Resident A4 was admitted to the facility on [DATE]. The resident had a physician's order dated June 12, 2021, for Coumadin 7.5 mg (a blood thinning medication to prevent the formation of blood clots), give 1 tablet by mouth daily until July 16, 2021, along with an order for a PT (Prothrombin time [PT] is a blood test that measures how long it takes blood to clot) and INR (INR stands for international normalized ratio. The INR provides some information about a person's blood's tendency to clot). Lab tests to be drawn on July 15, 2021. A review of the resident's Medication Administration Record (MAR) for the month of July 2021 indicated that Resident A4 received Coumadin 7.5 mg (milligrams) daily from July 12, 2021 through July 16 2021. A review of a lab report dated July 15, 2021, revealed the physician ordered PT/INR blood test was completed that day with results: PT- 28.8 seconds (normal 12.6-14.4 seconds) and INR-2.70 (normal 0.0-1. 11. If PT/INR test results are too high, it means that the resident's blood is clotting too slowly and a person is at risk of increased bleeding). A Physicians telephone order written on the lab report dated July 15, 2021 revealed same dose Coumadin 7. 5 mg by mouth at bedtime. Further review of the resident's July 2021 MAR revealed that the physician order for Coumadin 7.5 mg by mouth at bedtime order was not transcribed onto the electronic MAR. The MAR confirmed that Resident A4 did not receive Coumadin on July 17, 18 and 19, 2021. A review of a medication error report dated July 19, 2021, confirmed that nursing failed to transcribe the attending physicians order for Resident A4's daily Coumadin 7.5 mg resulting in her missing 3 daily doses of the medication. Clinical record revealed that Resident A3 had physician's orders dated June 9, 2021, for Coumadin 2 mg (a blood thinning medication to prevent the formation of blood clots), give 1 tablet by mouth daily until June 21, 2021. A review of the resident's Medication Administration Record (MAR) for the month of June 2021 indicated that Resident A3 received Coumadin 2 mg (milligrams) daily from July 9, 2021 through July 21, 2021. A physician telephone order, written on the lab report, dated July 18, 2021 revealed Coumadin 2 mg by mouth at bedtime. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the resident's July 2021 MAR revealed that the physician order for Coumadin 2 mg by mouth at bedtime was not transcribed onto the electronic MAR. As a result, Resident A3 did not receive any Coumadin on July 22, 23 and 24, 2021. A review of a medication error report dated July 25, 2021 revealed nursing failed to transcribe the attending physician orders for Resident A3's daily Coumadin 2 mg resulting in her missing 3 daily doses of the medication. During an interview on August 18, 2021, at approximately 1:00 PM the assistant Director of Nursing confirmed the medication errors in Resident's A4 and A3 Coumadin administration. She stated that the facility's medication error investigation did not identify the nursing staff responsible for the errors. She further stated that the facility's Coumadin order, unless specified by the physician, have no stop date. The DON explained that the nursing entered stop dates into the electronic MAR causing the Coumadin not to be ordered and the resident missing the above noted doses. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 26142 Based on a review of the facility's plan of correction for the deficiencies cited during the survey ending July 7, 2021, clinical records and outcome of the activities of the facility's quality assurance plan and staff interviews it was determined that the facility failed to develop and implement an effective quality assurance plan to correct and prevent continued quality deficiencies related to quality of care (bowel protocol) (Residents A1, A 2). Findings included: A review of the statement of deficiencies cited during the survey ending July 7, 2021, revealed that the facility developed a plan of correction that included a quality assurance monitoring plan to assure that corrections to the quality deficiencies were sustained. This plan was to be completed by August 10, 2021. In response to the deficiency cited under quality of care related to bowel protocol the facility's paln of correction indicated that: 2. The Director of Nursing will conduct a facility wide audit of current residents Physicians orders for bowel protocol to ensure the orders are reviewed and updated as needed. 3. The Director of Nursing or designee will reeducate the licensed staff on following bowel protocol physicians orders. 4. The Director of Nursing or designee will conduct weekly audits times three and monthly times four. The results of the audits will reviewed at the monthly QAPI meeting. However, during the revisit survey ending August 17, 2021, it was determined that the facility failed to follow physician orders for bowel protocol for two residents out of 8 sampled (Resident A1, A 2). The facility's quality assurance committee failed to develop and implement effective corrective actions plans to correct, and sustain correction of these quality deficiencies, and prevent recurrence of deficient practice, failing to improve the delivery of quality care and services to residents. Refer F684 28 Pa. Code 211.12(c) Nursing Services 28 Pa. Code 201.18(e)(1) Management