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	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Rehabilitation and Nursing Center	200 Second 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 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** 39235 Based on review of clinical records and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to demonstrate that licensed nurses timely and consistently evaluated the resident's condition and provided necessary care for one resident out of eight residents reviewed (Resident CR1) displaying a change, and continued decline, in condition, delaying the resident's transfer to the hospital, and subsequent admission to the intensive care unit and below the knee amputation, which compromised the resident's clinical condition and ability to maintain and/or reach his highest practicable physical well-being and delayed the provision of necessary care and treatment to prevent further decline in physical condition. Findings included: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient 's designated support person and other third parties. According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. (continued on next page)

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	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. A review of the clinical record revealed that Resident CR1, was most recently admitted to the facility on [DATE], with diagnoses, which included, dementia (a group of thinking and social symptoms that interferes with daily function; not a specific disease , dementia is a group of conditions characterized by impairment of at least two brain functions, such as memory and loss of judgement), chronic kidney disease, diabetes type 2, and peripheral vascular disease (a circulatory problem in which narrowed arteries reduce blood flow to your limbs). A review of a Annual Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 8, 2021, revealed that the resident was moderately impaired with a BIMS score of 11 (Brief Interview for Mental Status - a tool to assess cognitive function; a score of 8-12 indicates moderate impairment). The resident required limited assistance of one staff member for bed mobility and extensive assistance of one staff member for transfers, dressing, toileting and personal hygiene. Nursing progress notes dated August 13, 2021, at 3:51 PM, indicated that the resident had a change in condition, the resident required extra help in standing and a mechanical lift for transfer. Nursing noted that the physician was notified and had ordered lab work including, A CBC (a group of tests that evaluate the cells that circulate in blood), CMP (a test that measures 14 different substances in your blood), UA (urinalysis - a test of your urine used to detect and manage a wide range of disorders) and C&S (culture and sensitivity - laboratory techniques that allow a disease-causing microorganism to be identified, and that determine which antibiotics are sensitive to) and KUB (an X-ray study that allows your doctor to assess the organs of your urinary and gastrointestinal systems). Review of the clinical record revealed a progress note, an administration note, dated August 15, 2021, at 5:58 AM, noting that the resident was complaining of leg pain and was provided Tylenol (a non-narcotic pain reliever). A nursing progress note dated August 16, 2021, at 4:59 AM, revealed that the resident had been more tired the last few days. Nursing noted that the resident had edema (swelling) to the left leg. A nursing progress note dated August 16, 2021, at 10:50 AM, indicated that the physician had examined the resident and ordered x-rays of her left hip, pelvis, knee and a venous doppler (a diagnostic test used to check the circulation in the large veins in the legs) of the left lower extremity. A nursing progress note dated August 16, 2021, at 10:52 AM, indicated that the resident had recent confusion, lack of appetite and decreased mobility with complaints of lower extremity discomfort and was provided Tylenol. A nursing progress note dated August 16, 2021, at 2:34 PM, indicated that the resident was unable to walk because of weakness. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated August 17, 2021, at 5:33 AM, indicated that Resident CR1 was lethargic (tired), resting in bed, erythema (superficial reddening of the skin) to the left leg, cooler to touch than the right leg, with edema. A nursing note dated August 17, 2021, at 9:31 AM, indicated that the venous doppler was positive for a DVT (deep vein thrombosis - a blood clot which forms in one or more of the deep veins in your body, usually in your legs). The physician was notified, and new orders were obtained to start Eliquis (anticoagulant medication used to treat and prevent blood clots and to prevent stroke) BID (twice a day). The results of the diagnostic doppler study dated August 17, 2021, revealed the presence of a deep vein thrombosis involving the left mid to distal femoral vein. A nursing progress note dated August 19, 2021, at 4:53 PM, indicated that the resident had complained of right lower extremity pain, the physician was notified and ordered a venous doppler of the right lower extremity. A nursing progress note dated August 20, 2021, at 7:43 AM, indicated that the resident had been alert and oriented at the beginning of the shift, but at 1:00 AM displayed confusion, speaking of being at the movie theater. The resident's left leg continued to display erythema, and was cool to the touch in comparison with the right leg. A nursing progress note dated August 21, 2021, at 7:32 AM, indicated that the resident's left leg was red, purple and cool to touch. Review of the clinical record revealed a progress note, an administration note, on August 21, 2021, at 4:35 PM, indicating that the resident was complaining of left leg pain and was provided Tylenol. A nursing progress note dated August 21, 2021, at 5:57 PM, indicated that at the family's request, the resident had been sent to the ER for evaluation related to the positive DVT in the left leg. A further review of the progress notes revealed that the physician was not notified of the identified change in Resident CR1 left leg presentation as being red/purple as documented on August 21, 2021, at 7:32 AM, and leg pain on August 21, 2021, at 4:35 PM until the resident was transferred to the hospital per family request on August 21, 2021, at 5:57 PM. A nursing note dated August 22, 2021, at 8:24 PM, indicated that Resident CR1 was admitted to the ICU (Intensive Care Unit). A nursing progress note dated August 23, 2021, at 9:43 PM, indicated that the resident was scheduled for a left leg amputation on August 24, 2021. A review of Hospital documentation, ED provider notes, dated August 21, 2021, indicated that Resident CR1 was seen in the ED (emergency department) for evaluation of deep vein thrombosis, no palpable pulses on the left lower extremity, and left leg pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The ED documentation further indicated that the physician examination in ER identified that the resident's left lower extremity was cold inferior (below) the knee with color changes. The cardiovascular examination involving pulses of the left femoral (blood vessel in the thigh), left popliteal (hollow area back of the knee), left dorsalis pedis (blood vessel of the lower limb that carries to the surface of the foot), and left posterior tibial (posterior aspect of the lower leg) was zero (0). A further review of Hospital documentation, entitled Operative Report, dated August 24, 2021, indicated that Resident CR1 had received vascular surgery, for a non-salvageable left leg. It further indicated a left above knee amputation was performed. Interview with Employee 1, (RN), on September 8, 2021, at approximately 12:35 PM, revealed that the facility's expectation is continual monitoring and or assessment of Resident CR1's change in condition and known positive doppler (DVT). Employee 1 further confirmed that the facility had no documented evidence to demonstrate that licensed and professional nursing had performed ongoing monitoring and timely assessment of the resident's left lower extremity for approximately three days and had consulted with the physician regarding the continued decline in condition of the resident's lower leg, including discoloration, swelling and leg pain. The resident's family requested that the resident be transferred to the hospital because of the appearance of the resident's toes, pain and known DVT, where the resident was admitted to ICU and required a left above the knee amputation. Interview with the Nursing Home Administrator (NHA) on September 8, 2021, at approximately 1:20 PM confirmed there was no documented evidence in the resident's clinical record, at the time of the survey ending September 8, 2021, that the facility's professional nursing staff had continually monitored and assessed Resident CR1's change in condition, DVT, and signs and symptoms of a continued decline in condition and had timely consulted with the physician to ensure that the resident received timely and necessary medical care, at the level required, based on the resident's current clinical condition. 483.25 Quality of Care Previously cited 1/8/21, 5/14/21, 7/7/21, 8/17/21 28 Pa. Code 211.5 (f)(g)(h) Clinical Records Previously cited 1/8/21, 5/14/21, 7/7/21, 8/17/21 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services Previously cited 1/8/21, 5/14/21, 7/7/21, 8/17/21

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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** 39235 Based on review of clinical records and staff interview it was determined that the facility failed to ensure availability of physician prescribed medication for one resident (Resident 43) and accurate administration of medication to one resident (Resident CR2) out of eight sampled residents. Findings include: A review of the clinical record revealed that Resident 43 was admitted to the facility on [DATE]. The resident had a physician orders for Flecainide Acetate (used to prevent or treat irregular heartbeats) 50 mg twice daily (9:00 a.m. and 5:00 p.m.) for arrhythmias (irregular heartbeat). Nurse's notes dated September 7, 2021, at 7:49 p.m. indicated that the facility was awaiting a pharmacy dispense of this medication and it was presently not available for administration to the resident. Review of the resident's MAR (medication administration record) for September 2021 revealed that the resident did not receive Flecainide Acetate on September 7, 2021 at 5:00 p.m. as scheduled, with a notation to see nurses notes. There was no indication the resident's physician was made aware that the resident missed this dose. Interview with the Administrator on September 8, 2021, at 1:30 PM confirmed that Resident 43 did not receive the Flecainide Acetate on September 7, 2021 at 5:00 p.m. as ordered and also verified that the facility did not use a back-up pharmacy to timely obtain this medication The NHA also verified that the physician was not made aware of the missed dose. A review of the clinical record revealed that Resident CR2 was admitted to the facility on [DATE]. The resident had a physician orders for Vicodin (narcotic pain medication) 5-325 milligrams (mg) orally every 12 hours, as needed, for pain rated from 4-10 (on a scale of 1-10). Resident CR2' Medication Administration Records (MAR) for the month of September 2021 revealed that the resident received this pain medication on September 1, 2021, at 8:01 a.m. for a pain level of 3; on September 3, 2021 at 8:31 a.m. for a pain level of 3; September 4, 2021 at 11:24 a.m. for a pain level of 3; and September 5, 2021, at 8:35 a.m. for a pain level of 2. Staff administered this narcotic pain medication for pain rated below the physician prescribed pain scale and not in accordance with physician order. Further review of Resident CR2's clinical record revealed that the resident did not have a physician orders for as needed pain medication for pain rated from 1-3 since the resident's admission on August 6, 2021, through the resident's discharge on September 5, 2021. Neither the facility nor the pharmacist identified that the resident did not have a physician order for the treatment of mild pain or pain rated below a 4. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Administrator on September 8, 2021 at 1:30 p.m. confirmed that staff failed to accurately carry out the physician order for administration of the pain medication to Resident CR2. Staff administered Vicodin for a pain level of 3 and under, on 4 occasions 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.9(k) Pharmacy services.