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	12/21/2021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, facility reported documentation, and staff interview, it was determined that the facility failed to timely consult with the physician and notify a resident's representative of a change in condition, the onset of behavioral symptoms, for one resident out of 18 sampled (Resident CR2) Findings include: A review of the clinical record revealed that Resident CR2 was admitted into the facility on [DATE] and has diagnoses including 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). A review of a nursing note dated November 26, 2021, at 5:42 PM revealed that the resident arrived at the facility. The resident was confused at that time, unable to answer questions, and knew only his name. Nursing noted no other behaviors displayed upon admission. A review of a nursing progress notes dated November 28, 2021, at 1:27 AM revealed Resident CR2 took off his soiled brief and put feces on his own bed and on his sleeping roommate Resident 6. A review of facility reported documentation dated November 28, 2021, revealed that Resident CR2 removed his incontinence brief and smeared feces on his bed and on his sleeping roommate Resident 6. There was no documented evidence that the facility had notified Resident CR2's physician or the resident's representative of the resident's change in behavior and incident with Resident 6. Interview with the Director of Nursing on December 21, 2021, at approximately 4:00 PM confirmed the facility failed to notify the physician and the resident's responsible party of the resident's change in behaviors and incident with Resident 6. 28 Pa Code 211.12 (a)(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

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review the facility's abuse prohibition policy, clinical records and select facility investigative reports and staff interviews it was determined that the facility failed to ensure that one resident out of 18 sampled was free from sexual abuse, which caused severe bruising, pain and emotional upset (Resident 2). Findings include: Review of the facility's abuse policy dated as reviewed June 2021, indicated that the purpose of the document was to keep residents free from abuse, neglect and corporal punishment of any kind by any purpose. The facility will provide a safe resident environment and protect residents from abuse. The facility will keep residents free from abuse, neglect, misappropriation of resident property and exploitation. This includes freedom from verbal, mental, sexual or physical abuse, corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the residents medical symptoms. This protection extends to abuse by staff, consultants, contractors, volunteers, students and visitors (collectively staff). The definition of abuse to include; The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse or mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse to include, non-consensual sexual contact of any type with a resident who appears to want the contact to occur, but lacks the cognitive ability to consent or a resident who does not want the contact to occur. A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses to include dementia and cerebral vascular accident (stroke). A physician order dated November 19, 2021 was noted for Resident 2 to receive Plavix (a blood thinning medication that can increase the risk of bruising and bleeding) 75 mg by mouth for cerebral infarction, stroke. Resident 2's admission MDS assessment (Minimum Data Set - a federally mandated standardized assessment process to plan resident care) dated November 26, 2021 revealed Resident 2 was severely, cognitively impaired with a BIMS score of 3 (BIMS score is a measure of a resident's cognition), required staff assistance for activities of daily living and was slight of stature, 62 inches tall and weighed 116 pounds. Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnosis of a fractured hip, admitted for short term rehabilitation. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	An admission MDS assessment dated [DATE] revealed that Resident CR1 was cognitively intact with a BIMS score of 15, required limited staff assistance with activities of daily living. The resident's height was 67 inches tall and the resident weighed 162 pounds. The resident required the extensive assistance of one person for ambulating in the room at that time. A review of nursing documentation dated November 23, 2021, at 1:45 AM revealed Resident CR1 combative with staff. He was attempting to get into the medication cart located in the hallway next to the nurses station. A review of nursing documentation dated November 23, 2021 at 5 AM revealed Resident CR1 had been seated in the dining room with a sharps (a container for used for disposing of used needles and sharps instruments) container next to him on the floor. He was observed to urinate in the container before facility staff took it away from him During an interview December 21, 2021 at approximately 2 PM, the DON (director of nursing) stated that Resident CR1 was experiencing behaviors, which were not included in his person-centered care plan when reviewed during the survey of December 21, 2021. A review of Resident CR1's care plan dated November 17, 2021 revealed no behaviors were noted. There was no documented evidence that the facility had developed and implemented approaches to addresss and/or attempt to manage Resident CR1's unsafe and socially inappropriate behaviors. A review of a facility investigation report dated December 15, 2021, revealed that on December 15, 2021, at 1:45 AM Employee 1 (a nurse aide employed by a staffing agency) entered the room shared by Residents' 2 and CR1. Employee 1 witnessed Residents 2 and CR1 in the same bed together (Resident 2's bed). Resident CR1 was observed on top of Resident 2. Both residents were naked from the waist down. Resident 2 was positioned buttocks up and face down on the bed. Resident CR1 had his right leg on top of Resident 2. Resident CR1 was observed touching Resident 2's buttocks with his penis. Employee 1 immediately separated the residents by pushing Resident CR1 off Resident 2 and sought help from licensed nursing staff. A review of nursing documentation dated December 15, 2021 at 1:45 AM, revealed that Employee 1 reported that something really bad is happening now, you need to come to resident's room you need to see this. Employee 1 was very nervous, trembling and nearly crying. Employee 2 (RN) and Employee 3 (LPN charge nurse) noted we both ran to resident's room. When I (Employee 2), this writer entered the room, immediately noted that Resident 2 was in very compromising position. His head was toward the foot of the bed, he was in fetal position on his right side and he was naked from waist down his bottom was all exposed and slightly tilted to the side. Noted extreme bruising from left hip area all the way across his both buttocks and almost to the right hip area. Resident 2 does not have any notes re; potential fall in the last few days. Bruising is very dark blue especially over the buttocks that appeared in that darker room. According to this documentation Employee 2 initially thought that Resident 2 had been incontinent of stool and only had bruising over right hip, but with closer examination was able to definitely determine that, this dark area was in fact extremely dark fresh looking bruise not a bowel movement. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Employee 2 noted that Resident CR1 was in bed at the time that I (Employee 2 RN) entered the room, Resident CR1 was lying in supine position with his paints down to his ankles, his underwear was off, to his knees and his penis was covered with his left hand. Curtain was pulled close and Resident 2 was covered and taken out of the room. Resident 2 was brought to the nurses station for initial observation and then placed in room a different resident room. Resident 2 was upset and stating I can't take him (Resident CR1), need to find a nurse for me and I go home. Nursing assessment of Resident 2 revealed no visible rectal bleeding, but Resident 2 presented with a large amount of purple/blue bruising extending from his left hip area all the way across his both buttocks and almost to the right hip area. Extreme bruising noted from left hip on to across both buttocks and to right hip. Director of Nursing (DON) was made aware. Resident 2 was sent to the emergency room for evaluation on December 15, 2021. Local police were notified along with the Resident 2's physician and Responsible Party. A review of an employee witness statement dated December 15, 2021, no time noted, revealed that Employee 1 (agency nurse aide) stated I was doing my rounds and walked into {Residents' CR1 and 2's} room when I saw {Resident CR1} on top of {Resident 2} (in Resident 2's bed). They were both naked from the waist down. {Resident 2} was bottom up and face down and {Resident CR1} had his right leg on top of Resident 2. Resident CR1 was touching Resident 2's butt with his penis. I immediately moved Resident CR1 to his own side of the room and I ran for help. {Resident 2} told me he was tired of {Resident CR1} and wanted his own room. I ran for help. Employee 2 (RN) and 3 (LPN) helped me get Resident 2 dressed and out of that room. Resident 2 had bruises on his bottom and I helped to care for him on December 14, 2021, and he did not have those bruises at that time. A review of a witness statement dated December 15, 2021, no time, indicated Employee 3 (LPN) stated Called into {Resident CR1 and Resident 2's} room by Employee 1. {Resident CR1} was lying across his bed (the window bed) on his right side with his pants/brief down around his ankles. Resident 2 was lying in his bed, on his right side, with his right leg tucked back and his left leg out. He was naked from the waist down. He was in the fetal position with his buttocks exposed and tilted toward the ceiling. Bruising noted to both buttocks, dark purple in color. A statement from Resident CR1 dated December 15, 2021 (no time indicated) revealed that {Resident CR1} was questioned by the Director of Nursing (DON). Resident CR1 denied any contact with Resident 2, stating that he had not been out of bed since his admission to the facility. He also stated that he cannot walk without assistance. He stated that the girl Employee 1) saw something, but misunderstood. In response to staff informing Resident CR1 that he was observed naked from the waist down and on top of Resident 2, Resident CR1 stated that she (Employee 1) must be hallucinating and this is the most ridiculous thing he ever heard. Resident CR1 continued to state that he was unable to walk, alleging that there was no way he could have gotten out of bed and screwed his roommate and got back into bed. Resident CR1 again expressed that the whole thing is ridiculous. Someone else must have come in and screwed his roommate. The facility placed Resident CR1 on one to one staff supervision until the resident's discharge from the facility on December 17, 2021. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview with physical therapy staff on December 21, 2021, revealed that the Resident CR1 had received specialized rehab services during this stay. PT staff stated that Resident CR1, reached his maximum potential in physical therapy and was ambulating independently without staff assistance at the time of the sexual assault of Resident 2. Resident CR1 was discharged to home without services, on December 17, 2021, following his sexual abuse of Resident 2. A review of Resident 2's hospital emergency room discharge documentation dated December 15, 2021 at 9:09 AM revealed a discharge diagnosis of Sexual Assault of Adult. A review of nursing documentation dated December 16, 2021 2:53 PM revealed Resident 2 complained of pain. Tylenol (non narcotic pain medication) 325 mg, 1 tab, by mouth was given to Resident 2. The CRNP (Certified Registered Nurse Practioner) was contacted and ordered a stat (immediate) Lumbar Spine X-ray in response to resident complaints of pain. A review of a mobile x-ray report dated December 17, 2021 at 7:38 PM revealed the xray of the lumbar spine (lower spine) was completed in response to complaints of pain. The impression was noted as severe compression fracture (occurs when one or more bones in the spine weaken and crumple) superior end plate (complete burst fracture involves both endplates, the superior {upper} one as well as the inferior {lower}one). During an interview December 21, 2021 at approximately 3 PM the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to ensure that Resident 2 was free from sexual abuse perpetrated by Resident CR1. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 28 Pa. Code 201.14(a) Responsibility of Licensee Previously cited 7/7/21, 5/14/21, 1/8/21 28 Pa. Code 201.18 (e)(1) Management Previously cited 11/17/21, 8/17/21, 7/7/21, 5/14/21, 1/8/21 28 Pa. Code 201.29(a) Resident rights Previously cited 11/17/21, 8/17/21, 7/7/21, 5/14/21, 1/8/21 28 Pa. Code 201.29(c) Resident rights Previously cited 7/7/21, 5/14/21 28 Pa. Code 201.29(d) Resident rights Previously cited 7/7/21

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records, the facility's abuse prohibition policy and procedures and select investigative reports and staff interviews it was revealed that the facility failed to implement established procedures for the protection of a resident to prevent the potential for further abuse and the collection and protection of physical evidence following the sexual abuse to ensure a thorough investigation of the sexual assault of one resident out of 18 sampled (Resident 2). Findings Include: Review of the facility's abuse policy dated as reviewed June 2021, indicated that the purpose of the document was to keep residents free from abuse, neglect and corporal punishment of any kind by any purpose. The facility will provide a safe resident environment and protect residents from abuse. The facility will keep residents free from abuse, neglect, misappropriation of resident property and exploitation. This includes freedom from verbal, mental, sexual or physical abuse, corporal punishment, involuntary seclusion, and physical or chemical restraint not required to treat the residents medical symptoms. This protection extends to abuse by staff, consultants, contractors, volunteers, students and visitors (collectively staff). The definition of abuse to include; The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse or mental abuse including abuse facilitated or enabled through the use of technology. Sexual abuse to include, on-consensual sexual contact of any type with a resident who appears to want the contact to occur, but lacks the cognitive ability to consent or a resident who does not want the contact to occur. During the investigation, potential evidence will be preserved as much as possible. Upon suspicion/allegation of potential abuse or neglect, administrative personnel will immediately take measures to protect the alleged victim and integrity of the investigation. If the alleged perpetrator is a resident, the residents will be separated and monitored to minimize the risk of further abuse. A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses to include dementia and cerebral vascular accident (stroke). A physician order dated November 19, 2021 was noted for Resident 2 to receive Plavix (a blood thinning medication that can increase the risk of bruising and bleeding) 75 mg by mouth for cerebral infarction, stroke. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's admission MDS assessment (Minimum Data Set - a federally mandated standardized assessment process to plan resident care) dated November 26, 2021 revealed Resident 2 was severely, cognitively impaired with a BIMS score of 3 (BIMS score is a measure of a resident's cognition), required staff assistance for activities of daily living and was slight of stature, 62 inches tall and weighed 116. Clinical record review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnosis of a fractured hip, admitted for short term rehabilitation. An admission MDS assessment dated [DATE] revealed that Resident CR1 was cognitively intact with a BIMS score of 15, required limited staff assistance with activities of daily living. The resident's height was 67 inches tall and the resident weighed 162 pounds. A review of nursing documentation dated November 23, 2021, at 1:45 AM revealed Resident CR1 combative with staff. He was attempting to get into the medication cart located in the hallway next to the nurses station. During an interview December 21, 2021 at approximately 2 PM, the DON (director of nursing) stated that Resident CR1 was experiencing behaviors, which were not included in his person-centered care plan when reviewed during the survey of December 21, 2021. A review of Resident CR1's care plan dated November 17, 2021 revealed no behaviors were noted. A review of nursing documentation dated November 23, 2021 at 5 AM revealed Resident CR1 had been seated in the dining room with a sharps (a container for used for disposing of used needles and sharps instruments) container next to him on the floor. He was observed to urinate in the container before facility staff took it away from him. A review of a facility investigation report dated December 15, 2021, revealed that on December 15, 2021, at 1:45 AM Employee 1 (a nurse aide employed by a staffing agency) entered the room shared by Residents' 2 and CR1. Employee 1 witnessed Residents 2 and CR1 in the same bed together (Resident 2's bed). Resident CR1 was observed on top of Resident 2. Both residents were naked from the waist down. Resident 2 was positioned buttocks up and face down on the bed. Resident CR1 had his right leg on top of Resident 2. Resident CR1 was observed touching Resident 2's buttocks with his penis. Employee 1 immediately separated the residents by pushing Resident CR1 off Resident 2 and sought help from licensed nursing staff. A review of nursing documentation dated December 15, 2021 at 1:45 AM, revealed that Employee 1 reported that something really bad is happening now, you need to come to resident's room you need to see this. Employee 1 was very nervous, trembling and nearly crying. Employee 2 (RN) and Employee 3 (LPN charge nurse) noted we both ran to resident's room. When I (Employee 2), this writer entered the room, immediately noted that Resident 2 was in very compromising position. His head was toward the foot of the bed, he was in fetal position on his right side and he was naked from waist down his bottom was all exposed and slightly tilted to the side. Noted extreme bruising from left hip area all the way across his both buttocks and almost to the right hip area. Resident 2 does not have any notes re; potential fall in the last few days. Bruising is very dark blue especially over the buttocks that appeared in that darker room. According to this documentation Employee 2 initially thought that Resident 2 had been incontinent of stool and only had bruising over right hip, but with closer examination was able to definitely determine that, this dark area was in fact extremely dark fresh looking bruise not a bowel movement. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee 2 noted that Resident CR1 was in bed at the time that I (Employee 2 RN) entered the room, Resident CR1 was lying in supine position with his paints down to his ankles, his underwear was off, to his knees and his penis was covered with his left hand. Curtain was pulled close and Resident 2 was covered and taken out of the room. Resident 2 was brought to the nurses station for initial observation and then placed in room a different resident room. Resident 2 was upset and stating I can't take him (Resident CR1), need to find a nurse for me and I go home. Nursing assessment of Resident 2 revealed no visible rectal bleeding, but Resident 2 presented with a large amount of purple/blue bruising extending from his left hip area all the way across his both buttocks and almost to the right hip area. Extreme bruising noted from left hip on to across both buttocks and to right hip. Director of Nursing (DON) was made aware. Resident 2 was sent to the emergency room for evaluation on December 15, 2021. Local police were notified along with the Resident 2's physician and Responsible Party. A review of an employee witness statement dated December 15, 2021, no time noted, revealed that Employee 1 (agency nurse aide) stated I was doing my rounds and walked into {Residents' CR1 and 2's} room when I saw {Resident CR1} on top of {Resident 2} (in Resident 2's bed). They were both naked from the waist down. {Resident 2} was bottom up and face down and {Resident CR1} had his right leg on top of Resident 2. Resident CR1 was touching Resident 2's butt with his penis. I immediately moved Resident CR1 to his own side of the room and I ran for help. {Resident 2} told me he was tired of {Resident CR1} and wanted his own room. I ran for help. Employee 2 (RN) and 3 (LPN) helped me get Resident 2 dressed and out of that room. Resident 2 had bruises on his bottom and I helped to care for him on December 14, 2021, and he did not have those bruises at that time. A review of a witness statement dated December 15, 2021, no time, indicated Employee 3 (LPN) stated Called into {Resident CR1 and Resident 2's} room by Employee 1. {Resident CR1} was lying across his bed (the window bed) on his right side with his pants/brief down around his ankles. Resident 2 was lying in his bed, on his right side, with his right leg tucked back and his left leg out. He was naked from the waist down. He was in the fetal position with his buttocks exposed and tilted toward the ceiling. Bruising noted to both buttocks, dark purple in color. A statement from Resident CR1 dated December 15, 2021 (no time indicated) revealed that {Resident CR1} was questioned by the Director of Nursing (DON). Resident CR1 denied any contact with Resident 2, stating that he had not been out of bed since his admission to the facility. He also stated that he cannot walk without assistance. He stated that the girl Employee 1) saw something, but misunderstood. In response to staff informing Resident CR1 that he was observed naked from the waist down and on top of Resident 2, Resident CR1 stated that she (Employee 1) must be hallucinating and this is the most ridiculous thing he ever heard. Resident CR1 continued to state that he was unable to walk, alleging that there was no way he could have gotten out of bed and screwed his roommate and got back into bed. Resident CR1 again expressed that the whole thing is ridiculous. Someone else must have come in and screwed his roommate. A review of Resident 2's hospital emergency room discharge documentation dated December 15, 2021 at 9:09 AM revealed a discharge diagnosis of Sexual Assault of Adult. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon Employee 1's (agency nurse aide) discovery of the Resident CR1's sexual abuse of Resident 2 she separated the two residents, but then left them alone in their room to obtain the assistance of the licensed nurses. Employee 1 failed to ensure protection of Resident 2 from any potential additional abuse by Resident CR1. There was also no evidence from the scene was collected by facility staff (i.e.:sheets, clothing) to be given to investigating authorities. The facility failed to implement its established abuse procedure for protection and investigation of a instance of sexual abuse. During an interview December 21, 2021 at approximately 3 PM the Nursing Home Administrator and the Director of Nursing confirmed that the facility's abuse policy was not followed in response to Resident CR1's abuse of Resident 2. Employee 1 failed to remain with Resident 2 to protect him from further abuse and the facility did not collect and preserve potential evidence at the scene of the sexual assault. Refer F600. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.29 (a)(c)(d) Resident Rights 28 Pa Code 211.2 (c) Nursing services

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records and select facility policy, and staff and resident interviews it was determined that the facility failed to provide nursing services consistent with professional standards of quality by failing to ensure that licensed nurses timely administered residents' medications for three of 18 reviewed (Resident 3, 4, and 5). Findings included: 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 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. 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 including Medication Records. A review of facility policy entitled: Medication Administration indicated that medications are administered within 60 minutes of scheduled time. A review of the clinical record of Resident 3 revealed admission to the facility on [DATE], with diagnoses, which included type 2 diabetes (condition that affects the way the body processes blood sugar). A review of Resident 3's Medication Administration Record for November 2021 revealed that the resident was prescribed and scheduled to receive the following medications: Allopurinol Tablet 300 MG by mouth at 9:00 AM Ferrous Sulfate Tablet 325 MG by mouth at 9:00 AM Insulin Lispro 100 UNIT/ML Solution pen-injector Inject 5 unit at 9:00 AM Pravastatin Sodium Tablet 80 MG by mouth at 9:00 AM Protonix Tablet Delayed Release 40 MG by mouth at 9:00 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCl Tablet 50 MG by mouth at 9:00 AM Toresmide Tablet 20 MG by mouth at 9:00 AM Tradjenta Tablet 5 MG by mouth at 9:00 AM Vitamin D3 Tablet 50 MCG by mouth at 9:00 AM Cranberry Tablet 450 MG by mouth at 9:00 AM Glipizide Tablet 5 MG by mouth at 9:00 PM Potassium Chloride ER Tablet 20 MEQ by mouth at 9:00 AM Review of the resident's medication administration audit report for December 2021 indicated that on December 21, 2021, the medications, scheduled for 9 AM, were administered at 11:29 AM. These medications were administered 2 hours and 29 minutes after the scheduled time. A review of the clinical record of Resident 4 revealed admission to the facility on [DATE], with diagnoses, which included type 2 diabetes and peripheral vascular disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of Resident 4's Medication Administration Record for November 2021 revealed that the resident was prescribed and scheduled to receive the following medications: Atorvastatin Calcium Tablet 40 MG by mouth at 9:00 PM Trazodone HCl Tablet 150 MG by mouth at 9:00 PM Review of the resident's medication administration audit report for December 2021 indicated that on December 20, 2021, the medications, scheduled for 9 PM, were administered at 11:14 PM. These medications were administered 2 hours and 14 minutes after the scheduled time. A review of the clinical record of Resident 5 revealed admission to the facility on [DATE], with diagnoses, which included type 2 diabetes and myocardial infarction (a blockage of blood flow to the heart muscle) . A review of Resident 5's Medication Administration Record for November 2021 revealed that the resident was prescribed and scheduled to receive the following medications: Carvedilol Tablet 6.25 MG Give 1 tablet by mouth at 5:00 PM Eliquis Tablet 2.5 MG by mouth at 5:00 PM Docusate Sodium Capsule 100 MG by mouth at 5:00 PM Potassium Chloride ER Tablet Extended Release 30 MEQ by mouth at 5:00 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Claritin Tablet 10 MG by mouth at 5:00 PM Sertraline HCl Tablet 25 MG by mouth at 5:00 PM Lasix Tablet 60 MG by mouth at 5:00 AM. Review of the resident's medication administration audit report for December 2021 indicated that on December 20, 2021, the medications, scheduled for 5 PM, were administered at 9:36 PM. These medications were administered 4 hours and 36 minutes after the scheduled time. Interview with the Director of Nursing on December 21, 2021 at approximately 4:00 PM confirmed that the late medication administration is not consistent with the professional standards of practice and facility policy. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing Services 28 Pa. Code 211.5 (f)(g)(h) Clinical Records

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 41581 Based on observation, clinical record and select facility policy review and staff interview, it was determined that the facility failed to provide effective pain management and administer pain medication as prescribed by the physician for one of 18 residents reviewed (Resident 7). Findings include: A review of the facility's policy entitled Pain Management last reviewed by the facility June 1, 2021, indicated that residents are assessed and evaluated to identified pain and manage pain and symptoms with appropriate non-pharmacologic and pharmacologic interventions to assist the resident to attain or maintain the highest practicable level of well-being. Review of clinical record revealed that Resident 7, had a physician order dated December 15, 2021, for Vicodin tablet 5-300 MG (narcotic pain medication) one tablet by mouth every six hours as needed for pain management. Resident 7 also had a physician order for Tylenol 650 MG (non-narcotic pain medication) every six hours as needed for pain level 1 through 3 (on a scale of 1-10 with 10 being the most severe). Observations on December 21, 2021, at 1:50 PM, revealed that Resident 7 informed Employee 6 LPN (license practical nurse) that he was having pain and the resident requested his narcotic pain medication for a pain level of eight (on a pain scale of 1 to 10). The nurse was observed to check the medication cart and then tell the resident that his pain medication was still not available. The resident appeared visibly upset and asked the nurse when it was going to be available for him. Interview with Employee 6 on December 21, 2021, at the time of the observation revealed that the nurse stated that the Vicodin medication was ordered on December 15, 2021, but the facility never received it from the pharmacy as of the time of the survey December 21, 2021. Employee 6 stated that the resident had not received any Vicodin following the order date of December 15, 2021. An interview with Resident 7 on December 21, 2021, at the time of the observation revealed that the resident complained that he had gone 4 or 5 days without receiving the narcotic pain medication he requested. The resident stated his pain level was bad and rated it at an eight on the pain scale (from 1-10) Further observations on December 21, 2021, at 1:55 PM revealed Employee 6 administered two Tylenol to the resident for his pain. There was no evidence that the facility's licensed nursing staff had consulted with the physician when the Vicodin remained unavailable for alternate pain management option and observation revealed no evidence that staff implemented any non-pharmacological approaches in an attempt to reduce or alleviate the resident's pain. A review of a medication administration record (MAR) dated December 2021 revealed Employee 6 did not document that she administered Tylenol 650 mg to Resident 7 at 1:55 PM for a pain level eight, which was outside the physician's ordered parameters. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation was found in the resident's clinical record that the physician was made aware of the resident's pain and unavailability of medication to manage his pain. An interview with Resident 7 on December 21, 2021, at approximately 3:00 PM revealed that the resident stated that he was still in pain. The resident stated he has constant pain, and he has been asking for Vicodin every day since it has been ordered. The resident stated that he continues to be told it's not available for him to receive. He further stated they give him Tylenol in the meantime, but it does not help with his pain. An interview with the Director of Nursing (DON) on December 21, 2021, at approximately 4:00 PM confirmed facility failed to provide effective pain management and administer pain medication as prescribed 28 Pa. Code 211.2(a) Physician Services 28 Pa. Code 211.5(f)(g) Clinical records 28 Pa. Code 211.12(a)(c)(d)(1)(3)(5) Nursing Services

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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** 41581 Based on review of clinical records, observations, and resident and staff interview it was determined that the facility failed to provide routine drugs for one resident out of 18 residents reviewed (Resident 7). Findings include: Review of clinical record revealed that Resident 7, was admitted to the facility on [DATE], with diagnoses to include osteoarthritis (degeneration of joint cartilage and the underlying bone, most common from middle age onward. It causes pain and stiffness, especially in the hip, knee, and thumb joints). Further review of the clinical record revealed a physician order dated December 15, 2021, for Vicodin tablet 5-300 MG (narcotic pain medication) one tablet by mouth every six hours, as needed, for pain management. Observations on December 21, 2021, at 1:50 PM, revealed that Resident 7 told Employee 6 LPN (license practical nurse) that he was experiencing pain and requested his prn narcotic pain medication for a pain level of eight (on a pain scale of 1 to 10). Employee 6 was observed to look in the medication cart and then told the resident that the Vicodin was still not available. The resident appeared upset and asked Employee 6 when the Vicodin was going to be available. Interview with Employee 6 on December 21, 2021, at the time of the observation revealed that the Employee 6 stated that the medication was ordered for Resident 7 on December 15, 2021, but the facility has yet to receive it from the pharmacy. Employee 6 stated that Resident 7 has not received any Vicodin since it was ordered on December 15, 2021. Interview with the Nursing Home Administer on December 21, 2021 at approximately 4:00 PM confirmed that the facility failed to timely provide routine drugs prescribed for residents. Refer F697 28 Pa. Code 211.9 (a)(l)(d)(k) Pharmacy Services. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services. 28 Pa. Code 211.10(c)(d) Resident care policies

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 26142 Based on review of information submitted by the facility, select investigative reports, clinical records and employee personnel and training records it was revealed that the facility failed to provide training to agency employees on the facility's current abuse prohibition and response procedures. Findings include: Review of the facility's abuse policy dated as reviewed June 2021, indicated that sexual abuse included non-consensual sexual contact of any type with a resident who appears to want the contact to occur, but lacks the cognitive ability to consent or a resident who does not want the contact to occur. During the investigation, potential evidence will be preserved as much as possible. Upon suspicion/allegation of potential abuse or neglect, administrative personnel will immediately take measures to protect the alleged victim and integrity of the investigation. If the alleged perpetrator is a resident, the residents will be separated and monitored to minimize the risk of further abuse. A review of a facility investigation report dated December 15, 2021, revealed that on December 15, 2021, at 1:45 AM Employee 1 (a nurse aide employed by a staffing agency) entered the room shared by Residents' 2 and CR1. Employee 1 witnessed Residents 2 and CR1 in the same bed together (Resident 2's bed). Resident CR1 was observed on top of Resident 2. Both residents were naked from the waist down. Resident 2 was positioned buttocks up and face down on the bed. Resident CR1 had his right leg on top of Resident 2. Resident CR1 was observed touching Resident 2's buttocks with his penis. Employee 1 immediately separated the residents by pushing Resident CR1 off Resident 2 and sought help from licensed nursing staff. A review of nursing documentation dated December 15, 2021 at 1:45 AM, revealed that Employee 1 reported that something really bad is happening now, you need to come to resident's room you need to see this. Employee 1 was very nervous, trembling and nearly crying. Employee 2 (RN) and Employee 3 (LPN charge nurse) noted we both ran to resident's room. When I (Employee 2), this writer entered the room, immediately noted that Resident 2 was in very compromising position. His head was toward the foot of the bed, he was in fetal position on his right side and he was naked from waist down his bottom was all exposed and slightly tilted to the side. Noted extreme bruising from left hip area all the way across his both buttocks and almost to the right hip area. Resident 2 does not have any notes re; potential fall in the last few days. Bruising is very dark blue especially over the buttocks that appeared in that darker room. According to this documentation Employee 2 initially thought that Resident 2 had been incontinent of stool and only had bruising over right hip, but with closer examination was able to definitely determine that, this dark area was in fact extremely dark fresh looking bruise not a bowel movement. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employee 2 noted that Resident CR1 was in bed at the time that I (Employee 2 RN) entered the room, Resident CR1 was lying in supine position with his paints down to his ankles, his underwear was off, to his knees and his penis was covered with his left hand. Curtain was pulled close and Resident 2 was covered and taken out of the room. Resident 2 was brought to the nurses station for initial observation and then placed in room a different resident room. Resident 2 was upset and stating I can't take him (Resident CR1), need to find a nurse for me and I go home. A review of an employee witness statement dated December 15, 2021, no time noted, revealed that Employee 1 (agency nurse aide) stated I was doing my rounds and walked into {Residents' CR1 and 2's} room when I saw {Resident CR1} on top of {Resident 2} (in Resident 2's bed). They were both naked from the waist down. {Resident 2} was bottom up and face down and {Resident CR1} had his right leg on top of Resident 2. Resident CR1 was touching Resident 2's butt with his penis. I immediately moved Resident CR1 to his own side of the room and I ran for help. {Resident 2} told me he was tired of {Resident CR1} and wanted his own room. I ran for help. Employee 2 (RN) and 3 (LPN) helped me get Resident 2 dressed and out of that room. Resident 2 had bruises on his bottom and I helped to care for him on December 14, 2021, and he did not have those bruises at that time. A review of Resident 2's hospital emergency room discharge documentation dated December 15, 2021 at 9:09 AM revealed a discharge diagnosis of Sexual Assault of Adult. Upon Employee 1's (agency nurse aide) discovery of the Resident CR1's sexual abuse of Resident 2 she separated the two residents, but then left them alone in their room to obtain the assistance of the licensed nurses. Employee 1 failed to ensure protection of Resident 2 from any potential additional abuse by Resident CR1. There was also no evidence from the scene was collected by facility staff (i.e.:sheets, clothing) to be given to investigating authorities. The facility failed to implement its established abuse procedure for protection and investigation of a instance of sexual abuse. During an interview December 21, 2021 at approximately 3 PM the Nursing Home Administrator and the Director of Nursing confirmed that the facility's abuse policy was not followed in response to Resident CR1's abuse of Resident 2. Employee 1 failed to remain with Resident 2 to protect him from further abuse and the facility did not collect and preserve potential evidence at the scene of the sexual assault. A review of Employee 1's personnel data revealed that this agency nurse aide had worked at the facility on December 12, 13 and 14, 2021. There was no documented evidence that Employee 1 received training on the facility's abuse procedures prior to the first shift she worked in the facility. During an interview December 21, 2021 at approximately 3 PM the director of Human Resources confirmed the lack of facility specific abuse training provided to Employee 1. The Director of Human Resources provided documentation that only 32 of the noted 116 agency nursing staff used by the facility had received training on the facility's abuse policy and procedures prior to the first day of working in the facility. During an interview December 21, 2021 at approximately 3 PM the Nursing Home Administrator and the Director of Nursing confirmed that the facility utilizes multiple agency nursing staff daily and there is no documented evidence that all agency staff are trained on the facility's abuse policy. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.20(b) Staff development 28 Pa Code 201.18 (e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights