

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Kinzua Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Water Street Warren, PA 16365	
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on review of facility policies, clinical records, resident and staff interview, it was determined that the facility failed to provide a bath/shower per resident preference and failed to ensure that residents received assistance with bathing for two of 12 residents reviewed (Residents R3 and R4). Review of facility policy entitled Bed Bath, Shower/Tub dated 12/2/24, indicated The purpose of this procedure are to promote cleanliness, provide comfort to the resident. and Documentation 1. The date and time the shower/tub or bed bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub or bed bath. Review of Resident R3's clinical record revealed an admission date of 4/4/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow) and hypertension (high blood pressure). Review of Resident R3's physician's orders dated 4/8/25, revealed an order for shower every Wednesday and Saturday on evening shift. Review of Resident R3's task (an area where the nursing assistants document) for showers revealed he/she did not receive a shower on 7/5/25, and 7/19/25. Interview with Resident R3 on 7/23/25, at 10:30 a.m. revealed that he/she was very upset over not receiving their shower. He/she stated I want a shower, the staff told me I would get one this morning and its 10:30 a.m. Look at my hair it's greasy. Now it's almost lunch time and they will say they do not have the time to give me a shower. This is not the first time I waited a week to get a shower. Observations on 7/23/25, at 10:30 a.m. during the interview with Resident R3 revealed his/her hair appeared greasy and unkempt. Review of Resident R4's clinical record revealed an admission date of 1/9/24, with diagnoses that included Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat) and also identified their need for assistance with personal care. Review of Resident R4's physician's orders dated 4/24/25, revealed an order for shower every Tuesday and Friday on evening shift. Review of Resident R4's task for showers revealed he/she did not receive a shower on 7/11/25, 7/15/25, 7/18/25, and 7/22/25. Observations on 7/23/25, at 11:05 a.m. of Resident R4 revealed his/her hair appeared greasy and unkempt. During an interview on 7/23/25, at 1:00 p.m. the Director of Nursing (DON) confirmed that Residents R3 and R4 had not received showers as ordered and their hair appeared greasy and unkempt. The DON also confirmed that residents should receive their showers as ordered. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on review of facility policies, clinical records and staff interviews, it was determined that the facility failed to take appropriate timely action to obtain a medication for one of 12 residents reviewed (Resident R1). Review of a facility policy entitled Administering Medication dated 12/2/24, indicated medications are administered in a safe and timely manner, as prescribed. Review of a facility policy entitled Medications Ordering and Receiving from Pharmacy dated 12/2/24, indicated medications and related products are received from the dispensing pharmacy on a timely basis. Review of facility policy entitled Medication orders dated 12/2/24, indicated a verbal prescription for a scheduled II medication may be called in to a pharmacist directly by the prescriber. The supply can be delivered from the pharmacy or may be available from the emergency kit. Review of Resident R1's clinical record revealed an admission date of 6/23/25, with diagnoses that included encounter for palliative care (care and comfort measures), hypertension (high blood pressure), and dementia (a disease that affects short term memory and the ability to think logically). Review of Resident R1's nursing documentation revealed that on 6/21/25, at 8:00 p.m. the facility staff called the hospital for an update on Resident R1. The hospital staff informed the facility that Resident R1 was placed under comfort measures only. Further review of nursing documentation revealed a note dated 6/23/25, at 3:54 p.m. that Resident R1 returned to the facility and upon return, Resident R1 was not responding to verbal or physical touch was having agonal (gasping and/or labored) breathing and received morphine before leaving the hospital. Review of Resident R1's clinical record revealed discharge orders from the hospital with an order for morphine 5-20 mg (milligrams) by mouth every 30 minutes for pain or dyspnea (difficulty breathing and/or shortness of breath). Review of Resident R1's facility physician's orders revealed an order dated 6/23/25, for morphine 20 mg per ml (milliliter) give 5 ml by mouth every 4 hours as needed. Review of Resident R1's admission/re-admission evaluation dated 6/23/25, revealed under the pain evaluation Does the patient have a diagnosis or disease condition that causes or is likely to cause pain or discomfort? The answer was marked as yes. Further review of Resident R1's admission/re-admission evaluation revealed a base line care plan for pain with an intervention to administer medication per physician's orders. Review of Resident R1's pain scale revealed on 6/23/25, at 10:51 p.m. a pain scale with advanced dementia (a pain scale where you observe signs of pain in a resident when they are unable to tell you their pain) was marked as 4 with details (observed signs of pain) of breathing score of a 2 for observations of noisy labored breathing, long period of hyperventilation, Cheyne-Stokes (an irregular breathing pattern) respiration and score of a 2 for observations of facial grimacing. Another pain scale with advanced dementia on 6/24/25, at 7:13 a.m. was marked as 4 with details of breathing score of a 2 for observations of noisy labored breathing, long period of hyperventilation, Cheyne-Stokes respiration and score of a 2 for observations of facial grimacing. Review of Resident R1's June 2025, medication administration record revealed that morphine was not given until 10:43 a.m. on 6/24/25. During an interview with Registered Nurse Employee E1, he/she revealed that it can take between 30 minutes to two hours to pull a controlled medication out of the facilities dispensing unit in the facility. He/she said that the process is to notify the physician and then the physician must speak to the pharmacist then the facility would receive a pull code (permission to remove a controlled medication from the dispensing unit). He/she expressed the time depends on the physician and pharmacist communication with each other. He/she also expressed that it may take longer depending on the day and/or time of day. During an interview on 7/25/25, at 1:00 p.m. with the Director of Nursing (DON) confirmed that the facility did not get a pull code for Resident R1's morphine until 6/24/25, at approximately 10:30 a.m. The DON confirmed that Resident R1 returned to the facility with an order for morphine on 6/23/25. The DON also confirmed that Resident R1 had a pain scale of four on two different occasions prior to the morphine being obtained and that an as needed medication should be available and administered per physician's orders. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(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. Based on review of facility policy and clinical record review and staff interview, it was determined that the facility failed to ensure that medication was obtained and provided as ordered by the physician for one of 12 residents reviewed (Resident R2). Review of facility policy entitled Administering Medications dated 12/2/24, indicated Medications are administered in accordance with prescriber orders, including any required time frame. Review of facility policy entitled Medication Orders dated 12/2/24, indicated The prescriber is contacted by nursing for directions when delivery of a medication will be delayed, or the medication is not or will not be available. Review of Resident R2's clinical record revealed an admission date of 4/8/25, with diagnoses that included diabetes (a health condition that caused by the body's inability to produce enough insulin), hypertension (high blood pressure), and Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat). Review of Resident R2's clinical record revealed a physician's order for caladryl external lotion 1-8% apply to rash topically two times a day for seven days dated 6/26/25. Review of his/her treatment record for the months of June and July 2025, lacked evidence that caladryl lotion was applied per physician's order. Review of nursing documentation revealed the facility was waiting delivery of the caladryl lotion from the pharmacy. During an interview on 7/25/25, at 1:05 p.m. the Director of Nursing (DON) confirmed that there was no documented evidence that the caladryl lotion was received from the pharmacy or applied to Resident R2 per physician order. The DON also confirmed that the caladryl lotion should have been obtained from pharmacy and applied per physician order. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. code 211.12(d)(1)(3)(5) Nursing services		