STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395363	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kinzua Nursing and Rehab	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records and staff interviews, it was determined that the facility failed to maintain accurate and complete documentation for four of twelve residents reviewed (Residents R2, R3, R7 and R11) Findings include: Review of facility policy entitled Death of a Resident, Documentation, dated [DATE], indicated appropriate documentation shall be made in the clinical records concerning the death of a resident and that all information pertaining to a resident's death (i.e. date, time of death, name and title of individual pronouncing the resident dead, etc.) must be recorded in the nurse's notes. The policy further stated that the name of the mortician and person removing the deceased resident must be entered into the resident's medical record. Review of facility policy entitled Documentation of Wound Treatments, dated [DATE], indicated the facility completes accurate documentation of wound assessments and treatments and the wound treatments are documented at the time of each treatment. Resident R3's clinical record revealed an admission date of [DATE], with diagnoses that included brain cancer, cerebral edema (swelling of the brain), and pneumonia. Resident R3's clinical record revealed an expired / return not anticipated recapitulation form completed and signed by Resident R3's physician on [DATE], indicating Resident R3 passed away at the facility on [DATE]. Resident R3's clinical record progress notes lacked evidence of Resident R3's death including the date, time of death, name and title of individual pronouncing the resident, and name of person removing the deceased resident from the facility. During an interview on [DATE], at 1:23 p.m. the Director of Nursing (DON) confirmed that Resident R3's clinical record was incomplete and lacked evidence of Resident R3's death including the date, time of death, name and title of individual pronouncing the resident, and name of person removing the deceased resident from the facility. Resident R2's clinical record revealed an admission date of [DATE], with diagnoses that included acute osteomyelitis (bone infection) of left ankle and foot, stroke, diabetes, peripheral vascular disease and amputation of right leg below the knee. Review of Resident R2's August Treatment Administration Record revealed the following treatment orders: [DATE], for left plantar foot cleanse with wound cleanser, apply calcium alginate with silver (type of wound treatment) to wound base and cover with border gauze every day and evening shift. Out of 41 opportunities to document completion of the treatment, 26 opportunities were documented as completed and 15 were left blank. [DATE], to cleanse wound base of stump with normal saline solution, pat dry and apply xerofoam and cover with optifoam dressing every day shift. Out of 26 opportunities to document completion of the treatment, 19 were documented as completed and seven were blank, Resident R7's clinical record revealed an admission date of [DATE], with diagnoses that included hemiplegia and hemiparesis following a stroke, diabetes and neuropathy. Review of Resident R7's August Treatment Administration Record revealed the following treatment orders: [DATE], Desitin Zinc oxide cream apply to buttocks/groin every shift for skin protection. Out of 76 opportunities to document completion, 60 were documented as completed and 16 were blank. [DATE], cleanse left buttock with wound cleanser pat dry and apply medihoney cover with border gauze. Out of 4 opportunities to document completion, one was documented as completed and three were blank. [DATE], cleanse bilateral buttocks apply a thin layer of triad (wound treatment) to areas of excoriation leave open to air every shift for wound healing. Out of 20 opportunities to document completion, 15 were documented as complete and five were blank. [DATE], left buttock cleanse wound pack tunnel with iodoform apply calcium alginate to entire open area cover with border gauze every day shift. Out of five opportunities to document completion, one was documented as completed and four were blank. Resident R11's clinical record revealed an admission date of [DATE], with diagnoses that included pressure ulcer right heel, adult failure to thrive, protein calorie malnutrition, and bipolar disorder. Review of Resident R11's August Treatment Administration Record revealed the following treatment orders: [DATE], coccyx pressure ulcer cleanse with wound wash apply medihoney and cover with optifoam dressing every day shift. Out of 27 opportunities to document completion, 16 were documented as completed and 11 were blank. [DATE], weekly weights for four weeks every day shift every seven days. Out of four opportunities to document completion, one was documented and three were blank. [DATE], treatment to right heel cleanse with wound cleanser cover with betadine gauze and cover with bordered gauze dressing every day shift. Out of 19 opportunities to document completion, 10 were documented as completed and nine were blank. During an interview on [DATE], at 1:25 p.m. the DON confirmed that Resident R2's, R7's and R11's clinical records were incomplete regarding treatment documentation. 28 Pa. Code 211