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 02/26/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on review of the Pennsylvania Code Title 49. Professional and Vocational Standards, facility policies, facility job description, clinical records, and staff interviews, it was determined that the facility failed to follow nursing standards of practice to ensure admission medications are transcribed accurately for one of one residents reviewed (Resident R1). The facility's failure created a situation which placed the residents in Immediate Jeopardy of the likelihood of serious bodily injury, harm, or death for Resident R1.Findings include: Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.11. General functions of the Registered Nurse (RN) (a)(4) stated, Carries out nursing care actions which promote, maintain and restore the well-being of individuals and (b) The RN is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice. Review of facility policy entitled Medication and Treatment Orders dated 12/9/25, indicated Clarify the order and transcribe newly prescribed medications. on the Medication Administration Record (MAR). record or ensure the order is in the electronic MAR. and Written transfer orders (sent with a resident by hospital or other health care facility)-Implement a transfer order. unless the order is unclear or incomplete. the receiving nurse should verify the order with the current attending physician. Review of facility policy entitled Medication Errors dated 12/9/25, indicated the facility shall ensure medications will be administered. according to physician orders. Review of policy entitled Consult Pharmacist Reports dated 12/9/25, indicated Recommendations are acted upon and documented by the facility staff and/or prescriber. and Prescriber accepts and acts upon suggestion or rejects and provides and explanation for disagreeing. Review of facility Registered Nurse (RN) job description revealed The purpose of the Registered Nurse is to deliver care to residents utilizing the nursing process. while maintain all standards of professional nursing. Review of Resident R1's clinical record revealed an admission date of 1/8/26, with diagnoses that included schizoaffective disorder bipolar type (a mental illness that causes impaired thinking process with episodes of extreme mood swings with emotional highs and emotional lows), Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), and major depressive disorder (a serious mood disorder that causes feelings of sadness, loss of interest in daily activities, emotional and physical problems that impact daily life). Review of Resident R1's signed Consent to treat indicated I consent to receive care and services. as prescribed in the medical plan of care, and in accordance with applicable regulations, and professional and ethical standards. Review of Resident R1's transfer orders received upon admission revealed an order for lithium carbonate (psychotropic medication that affects the mind) 300 mg (milligram) tablet extended release orally with no stop date. Review of Resident R1's facility physician orders (orders that are transcribed by the facility (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

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 02/26/2026
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	into the resident's electronic medical record) dated 1/8/26, lacked evidence of an order for lithium 300 mg tablet extended release orally, therefore Resident R1 did not receive the lithium carbonate 300 mg from 1/8/26, through 2/8/26. Review of Resident R1's pharmacy admission medication review dated 1/8/26, indicated an alert that the pharmacy found a potential issue that actual or potential clinically significant irregularity had been identified. The review indicated under lithium carbonate capsule 150 mg that this dose falls below the recommended daily dose for this drug and is potentially subtherapeutic (too low of a dose). The pharmacy admission medication review lacked evidence that it was reviewed by the facility staff and/or physician. Review of Resident R1's MARs for the time period between 1/8/26, through 2/8/26, lacked evidence of an order for lithium carbonate 300 mg. Review of Resident R1's documentation from his/her last behavioral health visit dated 12/9/25, revealed active orders for lithium carbonate 150 mg every day and lithium carbonate 300 mg every day. Review of Resident R1's clinical record revealed progress notes:Progress note dated 1/30/26, at 4:19 a.m. indicating resident R1 was pacing, wandering, screaming, and yelling out. Progress note dated 1/30/26, at 6:39 a.m. indicated that resident R1 was being loud and vocal about being Christian and that this was out of the resident's usual behavior.Progress note dated 1/30/26, at 6:40 a.m. indicated that resident R1was hitting staff and talking about Jesus and seeing the light. Progress note dated 1/31/26, at 1:07 p.m. indicated the resident R1was really anxious and getting into arguments with other residents. Progress note dated 2/1/26, at 1:10 a.m. indicated that Resident R1was given an anti-anxiety medication for anxiety. Progress note dated 2/1/26, at 5:07 p.m. indicated that Resident R1was given anti-anxiety medication for anxiety. Progress note dated 2/2/26, at 7:57 a.m. indicated that resident R1was given anti-anxiety medication for anxiety. Progress note dated 2/2/26, at 7:17 p.m. indicated that Resident R1 asked for anxiety medication and he/she became frustrated because the nurse could not give the medication at that time. Progress note dated 2/3/26, 1:28 p.m. indicated that Resident R1 was in the day room being disruptive and was very anxious. Progress note dated 2/3/26, at 1:45 p.m. indicated that Resident R1 was given an anti-anxiety medication and he/she believed the medication was aspirin. Progress note dated 2/3/26, at 2:46 p.m. indicated that Resident R1was having increased agitation and anxiety he/she was being disruptive in the dining room. Progress note dated 2/4/26, at 7:46 p.m. indicated that Resident R1 appeared manic (showing uncontrolled excitement and energy) and argumentative. Progress note dated 2/5/26, at 3:08 a.m. indicated that Resident R1 had been up the majority of the shift wandering the halls and talking to him/herself. Progress note dated 2/5/26, at 7:43 a.m. indicated that the Resident R1 had not slept and was having flight of thoughts (a condition where a person's thoughts move quickly and jump between ideas) rambling about her past husbands and talking to her daughter who was not there. Progress note dated 2/5/26, at 10:32 a.m. indicated that Resident R1 appeared very agitated and having schizophrenic behaviors such as talking to self and to people not in the room. Progress note dated 2/5/26, at 11:09 p.m. indicated Resident R1 was very agitated, shaking and exhibiting flight of ideas. Progress note dated 2/6/26, at 3:56 a.m. indicated Resident R1 was pacing, wandering, rummaging, and hitting others. Progress note dated 2/6/26, at 10:23 a.m. indicated Resident R1 was not making sense and became increasingly agitated with staff and other residents. Progress note dated 2/7/26, at 7:23 a.m. indicated Resident R1 was ambulating in the hallways most of the night and having delusional thoughts (false beliefs that seem real even when provided with evidence which can lead to emotional distress and difficulty in functioning in daily life). Progress note dated 2/8/26, at 4:41 p.m. indicated that Resident R1 was receiving one on one care due to mania and having a fall that shift. Progress note dated 2/8/26, at 10:11 p.m. indicated Resident R1 needing one on one due to mania. Progress note dated 2/9/26, at 10:08 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicated Resident R1 was found on the floor.Progress note dated 2/9/26, at 7:55 p.m. indicated Resident R1 was found on floor and was in a manic state not able to answer questions.Progress note dated 2/9/26, at 8:13 p.m. indicated that Resident R1continued to present with mania. Daughter came in to see resident and stated that she had not seen her parent like this since she was a little girl.Progress note dated 2/9/26, at 9:14 p.m. indicated Resident R1 was confused and disoriented. Progress note dated 2/10/26, at 12:12 p.m. indicated that Resident R1 was transported to neurology appointment and from the appointment resident was being admitted to geriatric psych for evaluation. Review of Resident R1's care plans revealed a care plan dated 1/8/26, for at risk for adverse effects related to antipsychotic. medication, and a goal that the resident will show no side effects . Another care plan dated 1/8/26, for at risk for behavior symptoms related to schizoaffective disorder with interventions to administer medications per physician order. Review of Resident R1's laboratory results dated [DATE], revealed lithium level reference range (normal range) of 0.60 - 1.20 MMOL/L (millimoles per liter), and his/her results were 0.14 MMOL/L. Review of a neurology progress note dated 2/10/26, revealed that Resident R1's lithium doses were not correctly dosed and that Resident R1was showing signs of active psychosis. During an interview on 2/25/26, at 10:15 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R1 was sent to an appointment on 2/10/26, and has not returned to the facility. During interviews on 2/25/26, between 11:35 a.m. and 12:55 p.m. the Director of Nursing (DON) confirmed that Resident R1 had been having flight of thoughts and increased behaviors. The DON confirmed that Resident R1's order for lithium carbonate 300 mg was not transcribed from his/her transfer orders into his/her facility medication record. He/she confirmed that Resident R1's pharmacy admission medication review dated 1/8/26, indicating a potential clinically significant irregularity for resident R1's lithium carbonate order was identified and not addressed by the facility staff and/or physician. He/she also confirmed that the lithium carbonate 300 mg order should have been clarified by the physician and transcribed into Resident R1's medication record, and that the pharmacy medication review should have been addressed by the facility and physician. On 2/25/26, at 2:37 p.m. the Nursing Home Administrator (NHA) and DON were made aware that Immediate Jeopardy (IJ) existed for in the facility and that a corrective action plan was required. The IJ template was provided to the NHA at that time. On 2/25/26, at 5:28 p.m. an acceptable immediate action plan was approved which included the following interventions: All Registered Nurses will receive education regarding the proper process for entering physician orders for new admissions. Which will include thorough review of hospital discharge orders, accurate entry of orders into the electronic health record, and the required process for transcription and clarification to ensure accuracy within the medical record. Nursing staff will utilize a standard Medication Transcription/Clarification Tool during the admission process to ensure all medication orders are completely and accurately transcribed. Any discrepancies identified will be clarified with the physician prior to implementation, and physicians will be notified promptly of any transcription error or clarification needs. Implementing a revised admission process requiring use of the Medication Transcription/Clarification Tool to validate that medication orders are accurately entered into electronic health record and appropriately populate in the electronic medication administration record. Director of Nursing or designee will audit the last 30 days of admissions as well as any new admissions moving forward within 48 hours to verify accuracy of order transcription and clarification. admission audits will be conducted three times a week until sustained compliance is achieved. Audit results will be reviewed at the Quality Assurance Performance Improvement meetings and additional corrective action or re-education will be implemented as indicated by audit findings. On 2/26/26, between 10:30 a.m. and 12:24 p.m. review of staff education, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to prevent significant medication errors for one resident receiving a psychotic (mind altering) medication (Resident R1).Findings include: Review of Pennsylvania Code Title 49. Professional and Vocational Standards 21.11. General functions of the Registered Nurse (RN) (a)(4) stated, Carries out nursing care actions which promote, maintain and restore the well-being of individuals and (b) The RN is fully responsible for all actions as a licensed nurse and is accountable to clients for the quality of care delivered and (d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice. Review of a facility policy entitled Medication and Treatment Orders dated 12/9/25, indicated Clarify the order and transcribe newly prescribed medications. on the Medication Administration Record (MAR). record or ensure the order is in the electronic MAR. and Written transfer orders (sent with a resident by hospital or other health care facility)-Implement a transfer order. unless the order is unclear or incomplete. the receiving nurse should verify the order with the current attending physician. Review of a facility policy entitled Medication Errors dated 12/9/25, indicated the facility shall ensure medications will be administered. according to physician orders. Review of Resident R1's clinical record revealed an admission date of 1/8/26, with diagnoses that included schizoaffective disorder bipolar type (a mental illness that causes impaired thinking process with episodes of extreme mood swings with emotional highs and emotional lows), Parkinson's (a chronic and progressive movement disorder that causes shaking, slows a person's ability to move and worsens over time), and major depressive disorder (a serious mood disorder that causes feelings of sadness, loss of interest in daily activities, emotional and physical problems that impact daily life). Review of Resident R1's facility physician orders (orders that are transcribed by the facility into the resident's electronic medical record) dated 1/8/26, lacked evidence of an order for lithium 300 mg tablet extended release orally, therefore Resident R1 did not receive the lithium carbonate 300 mg from 1/8/26, through 2/8/26. During an interview on 2/25/26, at 11:57 a.m. the Director of Nursing (DON) confirmed that Resident R1's order for lithium carbonate 300 mg was not transcribed from his/her transfer orders into his/her medication record and subsequently Resident R1 was not administered the ordered medication. He/she also confirmed that the lithium carbonate 300 mg order should have been clarified by the physician and transcribed into Resident R1's medication record to ensure administration. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility records and job descriptions, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to make certain that admission medications are transcribed accurately.Findings include: The job description for the NHA revealed that the NHA's primary purpose is to supervise clinical and administrative affairs of nursing homes and related facilities. Duties of the nursing home administrator include overseeing staff, personal, financial matters, medical care, medical supplies, and facilities. The job description for the DON revealed that the DON's primary purpose is to provide expert professional knowledge and skills necessary to plan, organize, develop, and direct the overall operations of the Clinical Department in accordance with all current regulatory standards to ensure the highest degree of quality care. Based on the findings in this report that identified the facility failed to make certain that admission medications are transcribed accurately, the NHA and the DON failed to fulfill their essential job duties to ensure that the Federal and State guidelines and Regulations were followed. 28 Pa. Code 201.14(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services