

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

Printed: 07/18/2026
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 12/11/2025
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure physician orders, residents' Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments), electronic health record (EHR), and paper charts were consistent for two of 18 residents reviewed (Residents R9 and R52). Findings include: The facility policy entitled Advance Directives dated [DATE], indicated that The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive. The Director of Nursing (DON) or designee will notify the Attending Physician of advance directives so that the appropriate orders can be documented in the resident's medical record and plan of care. Resident R9's clinical record revealed an admission date of [DATE], with diagnoses that included hemiplegia affecting the right dominant side (paralysis on one side of the body), dysphagia (difficulty swallowing), and hypertension (high blood pressure). Resident R9's physician orders and EHR dated [DATE], revealed an order for cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest)-Full code. Resident R9's paper chart revealed a Do Not Resuscitate (DNR) form dated [DATE], with a bright DNR sticker in the front of the paper chart and deeper within the paper chart a POLST dated [DATE], that revealed Resident R9 requested CPR/Attempt Resuscitation. Resident R52's clinical record revealed an admission date of [DATE], with diagnoses that included chronic obstructive pulmonary disease (progressive lung disease that blocks airflow, causing breathing difficulties), heart failure, and irregular heartrate. Resident R25's physician orders and EHR dated [DATE], revealed an order for CPR-Full code. Resident R25's paper chart revealed a POLST dated [DATE], that revealed Resident R25 requested DNR. During an interview on [DATE], at 11:15 a.m. the DON, confirmed Residents R9 and R52's, physician's orders, POLST, EHR, and paper charts information were not consistent with each other. 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i)(vii) Medical records 28 Pa. Code 211.10(c) Resident care policies		

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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on review of the Minimum Data Set (MDS-periodic assessment of resident care needs) User's Manual, clinical record, and staff interview, it was determined that the facility failed to complete a comprehensive assessment after a significant change in condition for one of two residents reviewed receiving hospice services (Resident R49). Findings include: Review of the MDS User's Manual revealed that a significant change in status assessment is required to be performed when a terminally ill resident enrolls in a hospice program and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14-days from effective date of the hospice election. Resident R49's clinical record revealed an admission date of 5/27/23, with diagnoses that included dementia (group of symptoms affecting memory, thinking and social abilities), hypertension (high blood pressure), and dysphagia (difficulty swallowing). Further review of clinical record revealed a hospice contract to admit Resident R49 to hospice services on 7/30/25. Review of Resident R49's MDS's lacked evidence that a significant change MDS with an ARD completed within 14-days from when Resident R49 was admitted to hospice care was completed. During an interview on 12/10/25, at 1:05 p.m. the Director of Nursing confirmed that the facility failed to complete a significant change MDS when Resident R49 admitted to hospice services within 14-days from effective date of the hospice election. 28 Pa. Code 201.14(a) Responsibility of licensee		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to utilize infection control practices regarding Enhanced Barrier Precautions (EBPs-additional infection control precautions put in place for individuals who have an increased risk of multi-drug resistant organisms [MDROs] or who are colonized/infected with MDROs) for wound care for one of 18 residents reviewed (Resident R12). Findings include: Review of the facility policy entitled Enhanced Barrier Precautions dated 10/16/25, indicated EBPs are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO). It also indicated that gloves and gown are to be applied prior to performing the high contact resident care activities, which included wound care. Resident R12's clinical record revealed an admission date of 9/12/25, with diagnoses that included pressure ulcer of the sacral region stage 3 (wound involving full-thickness skin loss where the subcutaneous fat is visible), obstructive and reflux uropathy (complication with blocked urine flow and urine flowing backward from bladder to kidneys), and high blood pressure. Observations made prior to a pressure ulcer dressing change for Resident R12 on 12/10/25, at approximately 10:20 a.m. revealed a sign on the doorframe indicating EBPs in place, Licensed Practical Nurse (LPN) Employee E1 entered Resident R12's room without donning (putting on) a gown. During an interview on 12/10/25, at 10:35 a.m. LPN Employee E1 confirmed he/she did not don a gown prior to entering Resident R12's room. During an interview on 12/10/25, at 10:45 a.m. the Director of Nursing confirmed that EBPs were in place and employees should be wearing gloves and gowns when providing wound care 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		