STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395471	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Armstrong Rehabilitation and Nursing Center	265 South McKean Street Kittanning, PA 16201

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, job description, clinical record review, facility documents, resident interview, and staff interviews it was determined that the facility failed to provide care and services to meet the accepted standards of practice for one of two residents reviewed (Resident R1). Findings include: Review of the facility's Registered Nurse (RN) job description indicated the RN will prepare and administer medications as ordered by the physician. Review of facility policy Medication Administration dated 12/3/24, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compare medication source (such as, bubble pack and vials). Ensure that the six rights of medication administration are followed: - Right resident - Right drug - Right dose - Right route - Right time - Right documentation Review of the admission record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included influenza (flu- a viral infection of the nose, throat, and lungs), resistant hypertension (uncontrolled high blood pressure), and weakness. Review of Resident R1's progress note dated 2/1/25, at 10:00 a.m. indicated that Resident R1 had been given the wrong medication, and that family and physician were made aware. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's progress note dated 2/1/25, at 1058 a.m. indicated that Resident R1 Mistakenly received medication for her roommate (Resident R2), and that vital signs were being monitored every shift for three days. Review of Resident R2's clinical record revealed that her scheduled medications that morning included amlodipine besylate 5 milligrams (mg) (a medication used to treat high blood pressure), furosemide 20 mg (a water pill that prevents the body from absorbing too much salt, causing it to be passed in the urine), and potassium chloride extended release 20 milliequivalents (a mineral supplement used to treat low amounts of potassium in the blood). Review of Resident R1's clinical record revealed that she was not ordered any of the above medications. Review of a written statement dated 2/4/25, indicated that Registered Nurse (RN) Employee E1 Did not realize that there were two residents in the room as the curtain was pulled and there was a new admission. During an interview on 2/6/25, at 11:10 a.m. Resident R1 confirmed that she had received Resident R2's medication by mistake. Resident R1 stated that although she is fine now, the event was scary. During an interview on 2/6/25, at 2:17 p.m. RN Employee E1 stated that she was responsible for giving Resident R1 the wrong medication, and that she did not see that there were two residents in the room as the curtain was pulled on the other side which obstructed her view of Resident R2. RN Employee E1 stated that she realized her mistake immediately. During an interview on 2/6/25, at 2:22 p.m. the Nursing Home Administrator confirmed that the facility failed to provide care and services to meet the accepted standards of practice as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical record review, facility documents, resident interview, and staff interviews it was determined the facility failed to ensure that residents were free from any significant medication errors for one of two residents. (Resident R1). Findings include: Review of facility policy Medication Administration dated 12/3/24, indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compare medication source (such as, bubble pack and vials). Ensure that the six rights of medication administration are followed: - Right resident - Right drug - Right dose - Right route - Right time - Right documentation Review of the admission record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included influenza (flu- a viral infection of the nose, throat, and lungs), resistant hypertension (uncontrolled high blood pressure), and weakness. Review of Resident R1's progress note dated 2/1/25, at 10:00 a.m. indicated that Resident R1 had been given the wrong medication, and that family and physician were made aware. Review of Resident R1's progress note dated 2/1/25, at 1058 a.m. indicated that Resident R1 Mistakenly received medication for her roommate (Resident R2), and that vital signs were being monitored every shift for three days. Review of Resident R2's clinical record revealed that her scheduled medications that morning included amlodipine besylate 5 milligrams (mg) (a medication used to treat high blood pressure), furosemide 20 mg (a water pill that prevents the body from absorbing too much salt, causing it to be passed in the urine), and potassium chloride extended release 20 milliequivalents (a mineral supplement used to treat low amounts of potassium in the blood). Review of Resident R1's clinical record revealed that she was not ordered any of the above medications. (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a written statement dated 2/4/25, indicated that Registered Nurse (RN) Employee E1 Did not realize that there were two residents in the room as the curtain was pulled and there was a new admission. During an interview on 2/6/25, at 11:10 a.m. Resident R1 confirmed that she had received Resident R2's medication by mistake. Resident R1 stated that although she is fine now, the event was scary. During an interview on 2/6/25, at 2:17 p.m. RN Employee E1 stated that she was responsible for giving Resident R1 the wrong medication, and that she did not see that there were two residents in the room as the curtain was pulled on the other side which obstructed her view of Resident R2. RN Employee E1 stated that she realized her mistake immediately. During an interview on 2/6/25, at 2:22 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure that residents were free from any significant medication errors for one of two residents. (Resident R1). 28 Pa. Code 201.29 (j) Resident rights. 28 Pa Code: 201.18 (b)(1)(3) Management 28 Pa Code: 211.10 (d) Resident care policies