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	06/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, and staff interview, it was determined that the facility failed to ensure comfortable air temperature levels were provided for eight of 49 resident rooms (209, 212, 218, 219, 221, 302, 303, and 305). Findings Include: Review of the facility policy Safe and Homelike Environment indicated the facility will provide a safe, clean, comfortable, and homelike environment. The facility will provide and maintain comfortable and safe temperature levels. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit. Observations conducted on 6/10/25, from 2:32 p.m. to 2:59 p.m. with the Maintenance Director, Employee E7 revealed the following air temperatures: 2nd floor Nursing Floor -room [ROOM NUMBER]-82.2 of degrees Fahrenheit -room [ROOM NUMBER]-81.5 of degrees Fahrenheit -room [ROOM NUMBER]-82.4 of degrees Fahrenheit -room [ROOM NUMBER]-82.8 of degrees Fahrenheit -room [ROOM NUMBER]-82.8 of degrees Fahrenheit 3nd floor Nursing Floor -room [ROOM NUMBER]-83.5 of degrees Fahrenheit -room [ROOM NUMBER]-82.0 of degrees Fahrenheit -room [ROOM NUMBER]-82.4 of degrees Fahrenheit (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/10/25, at 5:11 p.m. the Nursing Home Adminstrator confirmed the facility failed to ensure comfortable air temperature levels were provided for eight of 49 resident rooms (209, 212, 218, 219, 221, 302, 303, and 305). 28 Pa. Code: 201.18(b)(3) Management

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and documentation, staff and resident interview it was determined that the facility failed to protect resident from neglect for two of four residents (Resident R4 and Resident R5). Findings include: Review of facility's policy dated 11/27/24, Abuse, Neglect, and Exploitation stated it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit abuse and neglect. Neglect means failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of Resident R4's admission record indicated resident was admitted to facility on 1/27/25, with the diagnosis of chronic pain, hemiplegia (paralysis of one side of the body), and weakness. Review of Residents R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/25, indicated the diagnoses were current. Review of Resident R4's care plan dated 3/23/25, revealed the resident was at risk for alternation in nutrition and hydration. Interventions included to assist as needed, encourage food and fluid as ordered. Review of Resident R4's Kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) on 6/10/25, revealed the resident required assistance with meals as needed. Review of undated facility documentation titled Total Feeds on 6/10/25, revealed Resident R4 must be fed for meals. During an interview on 6/10/25, at 12:32 p.m. Nurse Aide, Employee E2 was asked how to know which residents require assistance with meals. NA, Employee E2 stated It will populate a task, each person says set up, assist, or supervision. During an observation on 6/10/25, at 12:32 p.m. the lunch cart arrived to the 2C nursing unit. During an observation on 6/10/25, at 12:33 p.m. staff began passing trays to residents on the unit. During an interview on 6/10/25, at 12:52 p.m. Resident R4 stated they don't come in to help. Resident R4 stated I asked NA, Employee E4 to put in my dentures and NA, Employee E4 wouldn't do it. Resident R4 stated I don't eat much, if I could feed myself, I would. That's why I am drinking Ensure. Resident R4's dentures were observed on the bed side dresser, not in reach of the resident. During an observation on 6/10/25, at 1:02 p.m. NA, Employee E4 was observed picking up trays and placing them back on the lunch tray cart. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations completed on 6/10/25, from 12:21 p.m. to 1:03 p.m. Resident R4's door was closed. No staff member entered Resident R4's room. During an interview on 6/10/25, at 1:04 p.m. NA, Employee E4 confirmed Resident R4 was not offered their meal tray once the cart arrived to the floor. NA, Employee E4 confirmed Resident R4's dentures were not put in. During an interview on 6/10/25, at 1:07 p.m. Registered Nurse (RN), E3 indicated the nurse aides are expected to offer the residents meal once it arrives to the unit. During an interview completed on 6/10/25, at 11:11 a.m. the Assistant Director of Nursing, Employee E1 confirmed that the facility failed to protect Resident R4 from neglect. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of depression, anxiety, diabetes (occurs when your blood sugar is too high). Review of Resident R5's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses were current. Resident R5's Brief Interview for Mental Status (BIMS) assessment revealed the resident had a BIMS of 15, cognitively intact. During an interview on 6/10/25, at 11:50 a.m. Resident R5 was sitting in a wheelchair in the resident's common area and stated there is not enough staff. Resident R5 stated I have to wait a long time when I put on my call bell, I have to be put on a bed pan, I have to wait a while to be put on, then I already go in my pants. Resident R5 stated when I sit in the dayroom, I pee my pants and have to sit in it. Resident R5 stated staff puts me in the day room a little before lunch, then I sit there until after dinner mostly every day. Resident R5 stated this occurs five out of seven days a week and by the time the brief is changed it is soak and wet. Some aides tell me, just go in the dayroom and poop and pee in your pants. Review of Resident R5's June 2025 Documentation Survey Report v2 on 6/10/25, revealed the resident was incontinent of bladder on the following dates: -6/1/25, at 11:57 a.m. -6/2/25, at 8:56 a.m. -6/7/25, at 8:02 a.m. -6/8/25, at 10:23 a.m. -6/10/25, at 2:38 p.m. A further review of Resident R5's June 2025 Documentation Survey Report v2 failed to include evidence the resident was toileted on the night shift on 6/2/25, 6/5/25, and 6/7/25. The following was documented. -6/1/25, Resident R5 was toileted at 11:56 a.m. then at 6:38 p.m. a total of 6 hours and 42 minutes later. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-6/2/25, Resident R5 was toileted at 8:56 a.m. then at 6:03 p.m. a total of 9 hours and 7 minutes later. -6/3/25, Resident R5 was toileted at 9:03 a.m. then at 7:59 p.m. a total of 10 hours and 56 minutes later. -6/4/25, Resident R5 was toileted at 11:42 a.m. then at 5:19 p.m. a total of 5 hours and 37 minutes later. -6/5/25, Resident R5 was toileted at 9:56 a.m. then at 6:29 p.m. a total of 5 hours and 37 minutes later. -6/6/25, Resident R5 was toileted at 7:57 a.m. then at 4:53 p.m. a total of 8 hours and 56 minutes later. -6/7/25, Resident R5 was toileted at 9:12 a.m. then at 8:01 p.m. a total of 10 hours and 49 minutes later. -6/8/25, Resident R5 was toileted at 10:23 a.m. then at 7:36 p.m. a total of 9 hours and 13 minutes later. -6/9/25, Resident R5 was toileted at 6:16 a.m. then at 4:53 p.m. a total of 10 hours and 37 minutes later. During an interview on 6/10/25, at 5:10 p.m. the Nursing Home Administrator confirmed that the facility failed to protect resident from neglect for two of four residents (Resident R4 and Resident R5). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10 (a) (d) Resident care policies

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, staff, and resident interviews, it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance, including eating and toileting for four of seven residents (Resident R4, R5, R6, and R7). Findings include: Review of the facility's Activities of Daily Living (ADLs) policy dated 11/27/24, indicated care and services such as eating, transferring, and toileting will be provided. A resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Review of the facility's undated Certified Nursing Assistant job description revealed major duties and responsibilities include performing activities of daily living (ADL) for residents in accordance with care plans and established policies and procedures, assist nursing staff in carrying out toileting program activities, and complete flow sheets daily to indicate the specified task was done. Additional tasks included to treat all residents with dignity and respect, and to follow appropriate safety and hygiene measures at all times to protect residents an themselves. Review of Resident R4's admission record indicated resident was admitted to facility on 1/27/25, with the diagnosis of chronic pain, hemiplegia (paralysis of one side of the body), and weakness. Review of Residents R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/25, indicated the diagnoses were current. Review of Resident R4's care plan dated 3/23/25, revealed the resident was at risk for alternation in nutrition and hydration. Interventions included to assist as needed, encourage food and fluid as ordered. Review of Resident R4's Kardex (a documentation system that enables nurses to write, organize, and easily reference key patient information that shapes their nursing care plan) on 6/10/25, revealed the resident required assistance with meals as needed. Review of undated facility documentation titled Total Feeds on 6/10/25, revealed Resident R4 must be fed for meals. During an interview on 6/10/25, at 12:32 p.m. Nurse Aide, Employee E2 was asked how to know which residents require assistance with meals. NA, Employee E2 stated It will populate a task, each person says set up, assist, or supervision. During an observation on 6/10/25, at 12:32 p.m. the lunch cart arrived to the 2C nursing unit. During an observation on 6/10/25, at 12:33 p.m. staff began passing trays to residents on the unit. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/10/25, at 12:52 p.m. Resident R4 stated they don't come in to help. Resident R4 stated I asked NA, Employee E4 to put in my dentures and NA, Employee E4 wouldn't do it. Resident R4 stated I don't eat much, if I could feed myself, I would. That's why I am drinking Ensure. Resident R4's dentures were observed on the bed side dresser, not in reach of the resident. During an observation on 6/10/25, at 1:02 p.m. NA, Employee E4 was observed picking up trays and placing them back on the lunch tray cart. During observations completed on 6/10/25, from 12:21 p.m. to 1:03 p.m. Resident R4's door was closed. No staff member entered Resident R4's room. During an interview on 6/10/25, at 1:04 p.m. NA, Employee E4 confirmed Resident R4 was not offered their meal tray once the cart arrived to the floor. During an interview on 6/10/25, at 1:07 p.m. Registered Nurse (RN), E3 indicated the nurse aides are expected to offer the residents meal once it arrives to the unit. During an interview completed on 6/10/25, at 11:11 a.m. the Assistant Director of Nursing, Employee E1 confirmed that the facility failed to provide eating assistance for Resident R4. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of depression, anxiety, diabetes (occurs when your blood sugar is too high). Review of Resident R5's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses were current. Resident R5's Brief Interview for Mental Status (BIMS) assessment revealed the resident had a BIMS of 15, cognitively intact. During an interview on 6/10/25, at 11:50 a.m. Resident R5 was sitting in a wheelchair in the resident's common area and stated there is not enough staff. Resident R5 stated I have to wait a long time when I put on my call bell, I have to be put on a bed pan, I have to wait a while to be put on, then I already go in my pants. Resident R5 stated when I sit in the dayroom, I pee my pants and have to sit in it. Resident R5 stated staff puts me in the day room a little before lunch, then I sit there until after dinner mostly every day. Resident R5 stated this occurs five out of seven days a week and by the time the brief is changed it is soak and wet. Some aides tell me, just go in the dayroom and poop and pee in your pants. Review of Resident R5's June 2025 Documentation Survey Report v2 on 6/10/25, revealed the resident was incontinent of bladder on the following dates: -6/1/25, at 11:57 a.m. -6/2/25, at 8:56 a.m. -6/7/25, at 8:02 a.m. -6/8/25, at 10:23 a.m. -6/10/25, at 2:38 p.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A further review of Resident R5's June 2025 Documentation Survey Report v2 failed to include evidence the resident was toileted on the night shift on 6/2/25, 6/5/25, and 6/7/25. The following was documented. -6/1/25, Resident R5 was toileted at 11:56 a.m. then at 6:38 p.m. a total of 6 hours and 42 minutes later. -6/2/25, Resident R5 was toileted at 8:56 a.m. then at 6:03 p.m. a total of 9 hours and 7 minutes later. -6/3/25, Resident R5 was toileted at 9:03 a.m. then at 7:59 p.m. a total of 10 hours and 56 minutes later. -6/4/25, Resident R5 was toileted at 11:42 a.m. then at 5:19 p.m. a total of 5 hours and 37 minutes later. -6/5/25, Resident R5 was toileted at 9:56 a.m. then at 6:29 p.m. a total of 5 hours and 37 minutes later. -6/6/25, Resident R5 was toileted at 7:57 a.m. then at 4:53 p.m. a total of 8 hours and 56 minutes later. -6/7/25, Resident R5 was toileted at 9:12 a.m. then at 8:01 p.m. a total of 10 hours and 49 minutes later. -6/8/25, Resident R5 was toileted at 10:23 a.m. then at 7:36 p.m. a total of 9 hours and 13 minutes later. -6/9/25, Resident R5 was toileted at 6:16 a.m. then at 4:53 p.m. a total of 10 hours and 37 minutes later. Review of the clinical record revealed that Resident R6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of high blood pressure, diabetes, and cardiac arrythmia (irregular heart rate). Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/6/25, indicated diagnoses were current. Review of Resident R6's care plan revealed the resident required an assist of two staff members for toileting. During an interview on 6/10/25, at 11:30 a.m. Resident R6 stated They won't help me when I need it. Resident R6 stated At night, it's terrible here. Resident R6 stated Last night I had to wait a half hour. I got out of bed myself, it's so hard to get someone. I wheeled myself out. I took myself to bathroom. I waited forever to get back in bed. Resident R6 indicated every night I wait more than 30 minutes to use the bathroom. The resident stated the call light is turned on, they come in and say they have to get someone else, then they turn off the call light, then I still wait, and typically I fall asleep. It was indicated there is only one aide on floor on overnights. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident R6's June 2025 Documentation Survey Report v2 on 6/10/25, failed to include evidence the resident was toileted for 14 of 27 shifts from 6/1/25, to 6/9/25. Review of the clinical record revealed that Resident R7 was admitted to the facility on [DATE], with diagnoses of high blood pressure, diabetes, and depression. Review of Resident R7's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/24/25, indicated diagnoses were current. Review of Resident R7's care plan dated 9/27/24, stated to encourage resident to sit on toilet to evacuate bowels if possible. During an interview on 6/10/25, at 11:37 a.m. Resident R7 stated it can take staff a long time to respond to call bells. The resident stated they need assistance with reconnecting the oxygen tubing when going to the bathroom. Resident R7 indicated they have soiled themselves waiting to go to the bathroom. Resident R7 was asked how often that occurs and stated It happens a lot. A review of Resident R7's June 2025 Documentation Survey Report v2 on 6/10/25, failed to include evidence the resident was toileted for 12 of 27 shifts from 6/1/25, to 6/9/25. During an interview on 6/10/25, at 5:10 p.m. the Nursing Home Administrator confirmed that the facility failed to provide Activity of Daily Living (ADL) assistance, including eating and toileting for four out of seven residents (Resident R4, R5, R6, and R7). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(2.1) Management.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility policy, job descriptions, and resident and staff interviews, it was determined that the facility failed to have sufficient staff to provide nursing services including toileting for three of seven residents reviewed (Residents R5, R6, and R7). Findings include: Review of the facility's Activities of Daily Living (ADLs) policy dated 11/27/24, indicated care and services such as transferring and toileting will be provided. A resident who is unable to carry out activities of daily living will receive necessary services to maintain good grooming and personal hygiene. Review of the facility's undated Certified Nursing Assistant job description revealed major duties and responsibilities include performing activities of daily living (ADL) for residents in accordance with care plans and established policies and procedures, assist nursing staff in carrying out toileting program activities, and complete flow sheets daily to indicate the specified task was done. Additional tasks included to treat all residents with dignity and respect, and to follow appropriate safety and hygiene measures at all times to protect residents an themselves. During an interview on 6/10/25, at 10:58 a.m. Registered Nurse (RN), Employee E8 was asked if they had a concern for staffing. RN, Employee E8 stated the facility uses a lot agency that is unreliable. RN, Employee E8 stated I work once a week. RN, Employee E8 was asked if they have to stay later than there scheduled shift on the days they work and RN, Employee E8 stated I have to stay later to document and due to not having enough staff to fill the spots. During an interview on 6/10/25, at 11:18 a.m. Nurse Aide (NA), Employee E9 was asked if they had a concern for staffing and replied, the only real problem is night shift. NA, Employee E9 stated generally there is only one aide per unit. I feel a longer wait time for residents occurs when short staffed, anywhere from 15 to 30 minutes, maybe a little longer depending on the situation. Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of depression, anxiety, diabetes (occurs when your blood sugar is too high). Review of Resident R5's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses were current. Resident R5's Brief Interview for Mental Status (BIMS) assessment revealed the resident had a BIMS of 15, cognitively intact. During an interview on 6/10/25, at 11:50 a.m. Resident R5 was sitting in a wheelchair in the resident's common area and stated there is not enough staff. Resident R5 stated I have to wait a long time when I put on my call bell, I have to be put on a bed pan, I have to wait a while to be put on, then I already go in my pants. Resident R5 stated when I sit in the dayroom, I pee my pants and have to sit in it. Resident R5 stated staff puts me in the day room a little before lunch, then I sit there until after dinner mostly every day. Resident R5 stated this occurs five out of seven days a week and by the time the brief is changed it is soak and wet. Some aides tell me, just go in the dayroom and poop and pee in your pants. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R5's June 2025 Documentation Survey Report v2 on 6/10/25, revealed the resident was incontinent of bladder on the following dates: -6/1/25, at 11:57 a.m. -6/2/25, at 8:56 a.m. -6/7/25, at 8:02 a.m. -6/8/25, at 10:23 a.m. -6/10/25, at 2:38 p.m. A further review of Resident R5's June 2025 Documentation Survey Report v2 failed to include evidence the resident was toileted on the night shift on 6/2/25, 6/5/25, and 6/7/25. The following was documented. -6/1/25, Resident R5 was toileted at 11:56 a.m. then at 6:38 p.m. a total of 6 hours and 42 minutes later. -6/2/25, Resident R5 was toileted at 8:56 a.m. then at 6:03 p.m. a total of 9 hours and 7 minutes later. -6/3/25, Resident R5 was toileted at 9:03 a.m. then at 7:59 p.m. a total of 10 hours and 56 minutes later. -6/4/25, Resident R5 was toileted at 11:42 a.m. then at 5:19 p.m. a total of 5 hours and 37 minutes later. -6/5/25, Resident R5 was toileted at 9:56 a.m. then at 6:29 p.m. a total of 5 hours and 37 minutes later. -6/6/25, Resident R5 was toileted at 7:57 a.m. then at 4:53 p.m. a total of 8 hours and 56 minutes later. -6/7/25, Resident R5 was toileted at 9:12 a.m. then at 8:01 p.m. a total of 10 hours and 49 minutes later. -6/8/25, Resident R5 was toileted at 10:23 a.m. then at 7:36 p.m. a total of 9 hours and 13 minutes later. -6/9/25, Resident R5 was toileted at 6:16 a.m. then at 4:53 p.m. a total of 10 hours and 37 minutes later. Review of the clinical record revealed that Resident R6 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of high blood pressure, diabetes, and cardiac arrythmia (irregular heart rate). (continued on next page)

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	06/10/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R6's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/6/25, indicated diagnoses were current. Review of Resident R6's care plan revealed the resident required an assist of two staff members for toileting. During an interview on 6/10/25, at 11:30 a.m. Resident R6 stated They won't help me when I need it. Resident R6 stated At night, it's terrible here. Resident R6 stated Last night I had to wait a half hour. I got out of bed myself, it's so hard to get someone. I wheeled myself out. I took myself to bathroom. I waited forever to get back in bed. Resident R6 indicated every night I wait more than 30 minutes to use the bathroom. The resident stated the call light is turned on, they come in and say they have to get someone else, then they turn off the call light, then I still wait, and typically I fall asleep. Resident R6 stated there is only one aide on floor on overnights. Review of the clinical record revealed that Resident R7 was admitted to the facility on [DATE], with diagnoses of high blood pressure, diabetes, and depression. Review of Resident R7's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/24/25, indicated diagnoses were current. Review of Resident R7's care plan dated 9/27/24, stated to encourage resident to sit on toilet to evacuate bowels if possible. During an interview on 6/10/25, at 11:37 a.m. Resident R7 stated it can take staff a long time to respond to call bells. The resident stated I need assistance with reconnecting the oxygen tubing when going to the bathroom. Resident R7 indicated they have soiled themselves waiting to go to the bathroom. Resident R7 was asked how often that occurs and stated It happens a lot. During an interview on 6/10/25, at 1:11 p.m. the Assistant DIrector of Nursing (ADON), was notified of the concerns realted to Resident R5, R6, and R7 not being toileted timely. During an interview on 6/10/25, at 5:10 p.m. the Nursing Home Administrator confirmed that the facility failed to have sufficient staff to provide nursing services including toileting for three of seven residents reviewed (Residents R5, R6, and R7). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(4)(5) Nursing services

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	06/10/2025

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documents, and staff interviews, it was determined that the facility failed to schedule an appointment for outside services in a timely manner for one of three residents (Resident R5). Findings include: Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE], with diagnoses of depression, anxiety, diabetes (occurs when your blood sugar is too high). Review of Resident R5's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 5/2/25, indicated diagnoses were current. Review of Resident R5's physician order dated 5/23/25, indicated to consult dermatology for ongoing rash. Review of Resident R5's clinical record revealed on 5/27/25, Medical Doctor, Employee E4 seen the resident for a monthly follow up. The resident was complaining of their chronic rash, that is getting worse. The resident's skin was observed to have a rash present, hands are scaly, very dry. It was indicated a skin scraping was completed of the resident's left hand. A dermatologist consult has been ordered. Review of Resident R5's clinical record revealed on 5/30/25, Certified Registered Nurse Practitioner (CRNP), Employee E5 evaluated the resident for follow up of the rash. The rash was negative for scabies. Ongoing rash/pruritus to abdomen and left arm. It was indicated the resident was agreeable to a dermatologist appointment. During an interview on 6/10/25, at 3:42 p.m. Resident R5 was observed with a rash on their face, upper chest, and arms. Resident R5's hands were visible dry and scaly. Resident R5 stated They don ' t know what it is. Resident R5 stated the rash had be ongoing for three weeks. Review of Resident R5's clinical record on 6/10/25, failed to reveal evidence dermatology was consulted for Resident R5's ongoing rash as ordered. A total of 18 days since Resident R5 was ordered a dermatology consult. During an interview on 6/10/25, at 3:48 p.m. Scheduler, Employee E6 was asked if dermatology had been consulted for Resident R5. Scheduler, Employee E6 stated I do handle appointments, and not that I am aware of. Scheduler, Employee E6 confirmed the facility failed to timely consult dermatology as ordered. During an interview on 6/10/25, at 5:10 p.m. the Nursing Home Administrator confirmed the facility failed to schedule an appointment for outside services in a timely manner for one of two residents reviewed (Resident R5). 28 Pa. Code 211.12(d)(3) Nursing services