

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Armstrong Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, national accepted guidelines for Pressure Ulcers, and staff interview, it was determined that the facility failed to accurately assess pressure ulcers for one of three residents (Resident R2).</p> <p>Findings include:</p> <p>The facility policy Wound Treatment Management reviewed 12/3/24 indicated to promote wound healing of various wounds, it is the policy of the facility to provide evidence-based treatments in accordance with current standards or practice and physician orders. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders.</p> <p>Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of care needs) dated 5/22/25, indicated that Resident R2 had diagnoses that included thrombophilia(a condition where the blood has an increased tendency to clot), chronic embolism and rhabdomyolysis(condition where damaged muscle tissue breaks down, releasing its contents into the bloodstream).</p> <p>Review of the clinical admission assessment dated [DATE], indicated that Resident R2 has a stage 2 pressure ulcer on coccyx, unstageable pressure ulcer right medial ankle and a blister left heel.</p> <p>Review of physician orders dated 6/26/25 indicated Resident R2 did not have orders for these skin impairment's until 4/9/25.</p> <p>During an interview on 7/1/25, at 2:30 p.m. the Director of Nursing confirmed the facility failed to accurately assess pressure ulcers for one of three residents as required.</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>

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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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 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 ensure that nursing staff possessed the specific competencies and skill sets related to medication administration for one of two residents reviewed (Resident R1) which resulted in actual harm (chest pain, shortness of breath, and hospital transfer) for one of two residents (Resident R1). This was identified as harm for past non-compliance for Resident R1.</p> <p>Findings include:</p> <p>Review of the facility's Registered Nurse (RN) job description indicated the RN will prepare and administer medications as ordered by the physician.</p> <p>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:</p> <ul style="list-style-type: none"> <li>-</li> <li>Right resident</li> <li>-</li> <li>Right drug</li> <li>-</li> <li>Right dose</li> <li>-</li> <li>Right route</li> <li>-</li> <li>Right time</li> <li>-</li> <li>Right documentation</li> </ul> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior) and, weakness.</p> <p>Review of Resident R1's progress note dated 5/24/25, at 10:56 a.m. indicated that Resident R1 had been given the wrong medications that included amiodarone (medication used to regulate abnormal heart rhythms). Resident did not receive his own medications. Resident is complaining of mild chest pain and shortness of breath which started after med was given. Diagnosis, Assessment/Plan: Failure in dosage during medical care. This is an acute new problem. Condition is guarded given multiple meds including amiodarone, now symptomatic will send to ER (Emergency Room) for close monitoring. Orders: Transfer to emergency department for med error with amiodarone and complaints of chest pain and shortness of breath.</p> <p>Review of Resident R1's clinical record revealed that resident was not ordered amiodarone.</p> <p>Review of a written statement dated 5/24/25, indicated that Registered Nurse (RN) Employee E1 stated the following: I went into the room to give medication and gave the wrong medication to Resident R1. I realized at once I made a mistake. I assessed patient and got vitals and called for supervisor. I didn't realize it was 3 person room at this time. I try to double check myself.</p> <p>Review of documentation provided by the facility indicated that RN Employee E1 was suspended pending investigation, and opted to resign.</p> <p>The facility implemented a plan of correction that included the following:</p> <p>&amp;middot;</p> <p>Facility initiated education on 5/24/25, for all nursing staff including Registered Nurse's (RN's), and Licensed Practical Nurses (LPN's) for Safe Medication Administration. All nurses completed training and a quiz to demonstrate their understanding.</p> <p>&amp;middot;</p> <p>Reviewed RN Employee E1's file to ensure she had received education on Safe Medication Administration prior to the incident. This was verified to have been completed 2/12/25.</p> <p>&amp;middot;</p> <p>Evaluated all other residents on the same unit as Resident R1 to observe for adverse effects, which included obtaining vitals every four hours for 24 hours.</p> <p>&amp;middot;</p> <p>Ensured resident photos are up to date in the Electronic Charting System, which was completed on 5/28/25.</p> <p>&amp;middot;</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Audit medication carts starting 6/2/25.</p> <p>&amp;middot;</p> <p>Randomly observe Medication Pass to ensure 6 Rights of medication administration are being completed prior to medication administration, which began on 5/27/25.</p> <p>&amp;middot;</p> <p>QAPI (Quality Assurance Performance Improvement) conducted 5/24/25.</p> <p>During an interview on 7/1/25, at 9:50 a.m. LPN Employee E2 verified that he had received education on Safe Medication Administration and was able to verbalize understanding, adding You have to double check.</p> <p>During an interview on 7/1/25, at 9:56 a.m. RN Employee E3 verified that she had received education on Safe Medication Administration and was able to verbalize understanding, adding I check the orders at least twice, as well as the photo in the chart.</p> <p>During an interview on 7/1/25, at 10:06 a.m. LPN Employee E4 verified that she had received education on Safe Medication Administration and was able to verbalize understanding. She added that all residents have an updated picture in their chart, and that you have to look at their picture to make sure you have the right person.</p> <p>The facility has demonstrated compliance with the above since 5/24/25. Information was verified via review of Plan of Correction binder.</p> <p>During an interview on 7/1/25, at 1:42 p.m. with the Nursing Home Administrator (NHA) and review of the facility's immediate actions, education, and review of the QAPI monitoring process, it was verified that the facility had implemented a plan of correction and achieved compliance ensuring residents are provided adequate safety during medication administration.</p> <p>During an interview on 7/1/25, at 3:08 p.m. the Nursing Home Administrator, and Director of Nursing confirmed the facility failed to ensure that nursing staff possessed the specific competencies and skill sets related to medication administration, which resulted in harm for Resident R1.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, clinical record review, facility documents, and staff interviews it was determined the facility failed to ensure that residents were free from any significant medication errors which resulted in actual harm (chest pain, shortness of breath, and hospital transfer) for one of two residents (Resident R1). This was identified as harm for past non-compliance for Resident R1.</p> <p>Findings include:</p> <p>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:</p> <p>-</p> <p>Right resident</p> <p>-</p> <p>Right drug</p> <p>-</p> <p>Right dose</p> <p>-</p> <p>Right route</p> <p>-</p> <p>Right time</p> <p>-</p> <p>Right documentation</p> <p>Review of the admission record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that included high blood pressure, schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior) and, weakness.</p> <p>(continued on next page)</p>		

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