

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

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Form Approved OMB
No. 0938-0391

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 08/18/2025
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)		
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record and staff interview it was determined that the facility failed to ensure that in preparation for a room change each resident/responsible party received written notice, including the reason for the change before the resident room was changed for one of three residents (Resident R1). Findings include: Review of facility policy Notification of Changes dated 7/1/25, indicated the purpose of this policy is to ensure the facility promptly informs the resident, physician, and notifies the resident's representative when there is a change requiring notification. Circumstances requiring notification include accidents, significant changes, the need to change treatment, a transfer or discharge, and a notice of room change. Review of Resident R1 was admitted to the facility on [DATE]. Review of Resident R1 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/13/25, indicated diagnosis of anxiety (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and muscle weakness. Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was a 12 indicating Resident R1 was moderately impaired. Review of Resident R1's clinical record progress notes indicated on 7/15/25, that Resident R1 was transferred to the third floor with limited access to the elevator. Resident R1 was moved from second floor, resident is not happy at the moment, but willing to try this change. Review of Resident R1's clinical record failed to indicate that responsible party was notified of room change on 7/15/25. During an interview on 8/18/25, at 2:52 p.m. admission Employee E1 stated that Resident R1 had to be moved for safety reasons and did not ask/give options to the resident's responsible party prior to move. During an interview on 8/18/25, at 3:15 p.m. Director of Nursing confirmed that the facility failed to ensure that in preparation for a room change each resident/responsible party received written notice, including the reason for the change before the resident room was changed for one of three (Resident R1). 28 Pa. Code 201.29(a)(c.3)(1) Resident rights		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to make certain exit seeking/wandering residents had a person-centered care plan individualized to each specific resident's needs for one of six residents identified as high risk for wandering/elopement (Residents R1). Findings included: Review of the facility Care Plan Revisions Upon Status Change dated 7/1/25, indicated this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Review of the facility Elopements and Wandering Residents dated 7/1/25, indicated the facility ensures that residents who exhibit wandering behavior and are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered care addressing the unique factors contributing to wandering or elopement risk. The facility shall implement interventions to reduce risks and modify interventions when necessary. Review of Resident R1 was admitted to the facility on [DATE]. Review of Resident R1 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/13/25, indicated diagnosis of anxiety (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and muscle weakness. Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was a 12 indicating Resident R1 was moderately impaired. Review of Resident R1's Elopement Evaluation Form dated 7/22/25, indicated resident wanders through facility or prior residence, but does not leave interior setting. Elopement score was 13, indicating resident is a risk for elopement. Review of Resident R1's care plan revised on 7/22/25, indicated resident exhibits wandering. Intervention included: - Administer medication as ordered- Initiate psychiatric evaluation as needed- Initiate psychology evaluation as needed Review of Resident R1's care plan did not identify any resident person-centered interventions and/or goals specific to the resident in the wandering care plan. During an interview on 8/18/25, at 1:46 p.m. Director of Nursing confirmed the facility failed to make certain exit seeking/wandering residents had a person-centered care plan individualized to each specific resident's needs for one of six residents identified as high risk for wandering/elopement (Residents R1). 28 Pa. Code 201.24(e)(1)(5) Admissions Policy 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview it was determined that the facility failed to provide adequate supervision to prevent elopement for one of six residents (Resident R1). Findings include: Review of the facility Elopements and Wandering Residents dated 7/1/25, indicated the facility ensures that residents who exhibit wandering behavior and are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered care addressing the unique factors contributing to wandering or elopement risk. The facility shall implement interventions to reduce risks and modify interventions when necessary. Review of Resident R1 was admitted to the facility on [DATE]. Review of Resident R1 clinical record MDS (minimum data set a periodic assessment of resident needs) dated 6/13/25, indicated diagnosis of anxiety (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), (are a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and muscle weakness. Resident R1's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R1's BIMS score was a 12 indicating Resident R1 was moderately impaired. Review of Resident R1's Elopement Evaluation Form dated 7/22/25, indicated resident wanders through facility or prior residence, but does not leave interior setting. Elopement score was 13, indicating resident is a risk for elopement. During a review of Resident R1's progress note dated 7/15/25, indicated the following: - Received a phone call from dietary director that Resident R1 helped himself into the kitchen and took a tray and a few cups back to the second floor with him. She advised me that he always goes into the kitchen and has been told multiple times that he was not permitted in there due to safety concerns. To prevent injury or accident at this time, Resident R1 was transferred to the third floor with limited access to the elevator. During an interview on 8/18/25, Dietary Manager Employee E2 stated that on 7/15/25, employee was sitting in her office and observed Resident R1 head towards the kitchen. He asked for a tray and two coffee mugs. Resident R1 stated he wanted to show his roommate how to put his finished tray onto the food cart like he does. Dietary Manager Employee E2 educated resident that was not a good idea and escorted resident back to unit. During a review of Resident R1's clinical record, the facility failed to have a physical assessment completed of resident upon return to unit, and the physician and the resident's responsible party were not made aware of incident on 7/15/25. During an interview on 8/18/25, at 11:57 a.m. Director of Nursing (DON) confirmed that Resident R1 has a history of wandering, he did go into an area that was not designated for residents, and that the resident was identified in the area by a dietary staff member who escorted resident back to the nursing unit. During an interview on 8/18/25, at 2:30 p.m. DON confirmed that the facility failed to provide adequate supervision to prevent elopement and failed to complete proper assessments and notifications after an incident occurs for one of six residents (Resident R1). 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		