| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395471 | A. Building<br>B. Wing | 02/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Armstrong Rehabilitation and Nursing Center | 265 South McKean Street<br>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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**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 one of five residents (Resident R1).Findings include: Review of facility's policy dated 7/1/25, 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 Registered Nurse, Employee E1's signed job description dated 11/4/25, revealed major duties and responsibilities include ensuring policies and procedures are complied with by nursing personnel assigned, participates in the admission, discharge, and transfers of residents as required, assesses for changes in resident's status, notifying the physician and resident family or representative and documenting according, prepares and administers medications as per physicians' orders and observes for adverse effects as indicated. Review of Residents R1's admission record indicated the resident was admitted on [DATE], with diagnoses of constipation, high blood pressure, and cervicalgia (neck pain). Review of Resident R1's progress note dated 2/12/26, at 9:16 a.m. entered by Registered Nurse (RN), Employee E1 revealed Resident R1 was admitted from another facility and his last bowel movement was 2/5/26. Review of Resident R1's progress note dated 2/12/26, at 5:35 p.m. entered by Registered Nurse (RN), Employee E1 revealed the resident requested to go to the hospital for abdominal pain and constipation. He called 911 himself. Review of facility documents revealed RN, Employee E1 was the RN, Supervisor on duty from 7 a.m. to 7 p.m. Review of Nurse Aide (NA), Employee E2's witness statement dated 2/12/26, stated at 3:20 p.m. Resident R1 rang and wanted to see RN Supervisor, Employee E1 to go to the emergency room. NA, Employee E2 notified RN, Supervisor, Employee E1. While walking down the hall to take a break, Resident R1 rang again and stated he was going to call. RN Supervisor, Employee E1 stated she did his paperwork and wasn't going back. I did not see her go to his room at all. NA, Employee E2 stated RN, Supervisor, Employee E1 told Resident R1 he couldn't come back here while the ambulance workers were there. Review of Licensed Practical Nurse (LPN), Employee E3's witness statement dated 2/12/26, revealed LPN, Employee E3 overheard Resident R1 tell NA, Employee E2 that he wanted to go to the hospital. RN, Supervisor, Employee E1 was made aware. LPN, Employee E3 stated Resident R1 told her he has been asking all day to be sent to the hospital. The resident was asked what was wrong and he indicated he has not had a bowel movement in 7-10 days and he had a short stay at hospital and the other facility he came from didn't really do anything for him. As LPN, Employee E3 was walking back down hall, RN, Supervisor Employee E1 stated she did his paperwork and didn't know what else she could do for him. Resident R1's call bell went off again and RN Supervisor, Employee E1 could be heard from desk saying, I already know what he wants.<br><br>(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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN, Employee E3 alerted the Social Worker of a grievance concern, and the Director of Nursing was notified. When LPN, Employee E3 returned to Resident R1's room, he was on the phone with 911. Later, RN Supervisor Employee E3 asked LPN, Employee E3 Do you think I should send him out if he wants sent out? LPN, Employee E3 responded Yes and entered the resident's room and told the resident to wait until after dinner and she would call 911 and get him out. RN Supervisor then went to feed resident. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated the diagnoses were current. Review of information submitted to the State Agency on 2/16/26, by the Director of Nursing revealed on 2/13/26, Resident R1 stated he wanted to go to the hospital, and the Licensed Practical Nurse (LPN) and Nurse Aide (NA) reported to RN, Supervisor, Employee E1 that the resident was requesting to be sent out. RN Supervisor, Employee E1 refused to assess resident and refused to send him out to the hospital. During an attempted phone interview on 2/25/26, at 10:24 a.m. RN, Employee E1 was unavailable for an interview. During an interview on 2/25/26, at 10:38 a.m. the Director of Nursing (DON) confirmed Resident R1's Discharge Transition Packet dated 2/12/26, confirmed the resident's last bowel movement was 2/4/26, a total of eight days. During an interview on 2/25/26, at 10:50 a.m. Resident R1 confirmed when he was initially admitted to the facility he complained of abdomen pain and had to go to the hospital. During an interview on 2/25/26, at 10:58 a.m. Nurse Aide, Employee E2 stated Resident R1 wanted to go to the hospital and when she notified RN, Supervisor, Employee E1 she failed to go in and assess the resident. NA, Employee E2 stated the resident was complaining he hadn't moved his bowels. During an interview on 2/25/26, at 11:07 a.m. LPN, Employee E4 stated if a resident has not had a bowel movement in three days, the bowel protocol would be initiated. It was indicated for residents newly admitted , their last bowel movement is assessed upon admission. Medications for the bowel protocol are automatically put in place upon admission. Staff can also review discharge paperwork to see when a residents last bowel movement was. If a resident has a change in condition, they must be assessed, vitals obtained, and the physician is notified. During an interview on 2/25/26, at 11:09 a.m. LPN, Employee E3 stated she worked 3 p.m. to 11 p.m. on 2/12/26. LPN, Employee E3 was notified Resident R1 wanted to talk with a supervisor and go to the hospital. It was indicated Resident R1 was asking all day. Around 5 p.m. Resident R1 rang his call bell again and requested to see supervisor and go to hospital. RN, Supervisor R1 failed to assess resident and Resident R1 called 911 himself. LPN, Employee E3 stated the resident was having abdomen pain from a bowel obstruction. LPN, Employee E3 stated The resident had an order for citrus magnesium from the other facility, and I don't think he got any of it. During an interview on 2/25/26, at 1:18 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to protect resident from neglect for one of five residents (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.10 (a) (d) Resident care policies |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**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 report an allegation of neglect within 24 hours to the local state field office for one of two residents (Resident R1).Findings include: Review of facility's policy dated 7/1/25, 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. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within a specific timeframe; immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of Residents R1's admission record indicated the resident was admitted on [DATE], and readmitted [DATE], with diagnoses of constipation, high blood pressure, and cervicalgia (neck pain). Review of Resident R1's progress note dated 2/12/26, entered by Registered Nurse (RN), Employee E1 revealed the resident requested to go to the hospital for abdominal pain and constipation. He called 911 himself. Review of information submitted to the State Agency on 2/16/26, by the Director of Nursing revealed on 2/13/26, Resident R1 stated he wanted to go to the hospital, and the Licensed Practical Nurse (LPN) and Nurse Aide (NA) reported to RN, Supervisor, Employee E1 that the resident was requesting to be sent out. RN Supervisor, Employee E1 refused to assess resident and refused to send him out to the hospital. The facility failed to report the allegation of neglect within 24 hours to the local state field office. During an interview on 2/25/26, at 12:37 p.m. the Director of Nursing confirmed allegations of neglect must be reported to the appropriate agencies within 24 hours. During an interview on 2/25/26, at 1:18 p.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to report an allegation of neglect within 24 hours to the local state field office for one of two residents (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1) Management. 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code: 211.10(d) Resident care policies. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of five residents (Resident R1).Findings include: Review of facility Bowel Routine Policy last reviewed 7/1/25, indicated each resident will have routine bowel elimination. The purpose is to address the resident's individual needs with respect to routine bowel movements, initiate appropriate strategies and interventions, and monitor and evaluate resident outcomes. Give Milk of Magnesia 30 ml if no bowel movement in 72 hours (Day 3 without a bowel movement), if ineffective give Dulcolax Suppository. Administer fleet enema if Dulcolax Suppository is ineffective. Call physician if fleet enema is ineffective. Review of Residents R1's admission record indicated the resident was admitted on [DATE], with diagnoses of constipation, high blood pressure, and cervicalgia (neck pain). Review of Resident R1's progress note dated 2/12/26, at 9:16 a.m. entered by Registered Nurse (RN), Employee E1 revealed Resident R1 was admitted from another facility and his last bowel movement was 2/5/26. Review of Resident R1's clinical record for 2/12/26, failed to reveal Resident R1 had a bowel movement. Review of Resident R1's physician order dated 2/12/26, indicated to administer 30 milliliter (ml) Milk of Magnesia Suspension 7.75 % (Magnesium Hydroxide) by mouth as needed for constipation, if no bowel movement in 48 hours. Review of Resident R1's physician order dated 2/12/26, indicated to insert 1 Dulcolax Suppository 10 MG (Bisacodyl) suppository rectally as needed for constipation if Milk of Magnesia is ineffective. Review of Resident R1's physician order dated 2/12/26, indicated to insert 1 Fleet Enema 7-19 GM/118ML (Sodium Phosphates) applicatorful rectally as needed for constipation, if no bowel movement after Dulcolax suppository. Review of Resident R1's February 2026 Medication Administration Record (MAR) failed to include evidence the resident's medications were administered as ordered on 2/12/26. Review of Resident R1's progress note dated 2/12/26, at 5:35 p.m. entered by Registered Nurse (RN), Employee E1 revealed the resident requested to go to the hospital for abdominal pain and constipation. He called 911 himself. Review of Nurse Aide (NA), Employee E2's witness statement dated 2/12/26, stated at 3:20 p.m. Resident R1 rang and wanted to see RN Supervisor, Employee E1 to go to the emergency room. NA, Employee E2 notified RN, Supervisor, Employee E1. While walking down the hall to take a break, Resident R1 rang again and stated he was going to call. RN Supervisor, Employee E1 stated she did his paperwork and wasn't going back. I did not see her go to his room at all. NA, Employee E2 stated RN, Supervisor, Employee E1 told Resident R1 he couldn't come back here while the ambulance workers were there. Review of Licensed Practical Nurse (LPN), Employee E3's witness statement dated 2/12/26, revealed LPN, Employee E3 overheard Resident R1 tell NA, Employee E2 that he wanted to go to the hospital. RN, Supervisor, Employee E1 was made aware. LPN, Employee E3 stated Resident R1 told her he has been asking all day to be sent to the hospital. The resident was asked what was wrong and he indicated he has not had a bowel movement in 7-10 days and he had a short stay at hospital and the other facility he came from didn't really do anything for him. As LPN, Employee E3 was walking back down hall, RN, Supervisor Employee E1 stated she did his paperwork and didn't know what else she could do for him. Resident R1's call bell went off again and RN Supervisor, Employee E1 could be heard from desk saying, I already know what he wants. LPN, Employee E3 alerted the Social Worker of a grievance concern, and the Director of Nursing was notified. When LPN, Employee E3 returned to Resident R1's room, he was on the phone with 911. Later, RN Supervisor Employee E3 asked LPN, Employee E3 Do you think I should send him out if he wants sent out? LPN, Employee E3 responded Yes and entered the<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident's room and told the resident to wait until after dinner and she would call 911 and get him out. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/19/26, indicated the diagnoses were current. During an attempted phone interview on 2/25/26, at 10:24 a.m. RN, Employee E1 was unavailable for an interview. During an interview on 2/25/26, at 10:38 a.m. the Director of Nursing (DON) confirmed Resident R1's Discharge Transition Packet dated 2/12/26, confirmed the resident's last bowel movement was 2/4/26, a total of eight days. During an interview on 2/25/26, at 10:50 a.m. Resident R1 confirmed when he was initially admitted to the facility he complained of abdomen pain and had to go to the hospital. During an interview on 2/25/26, at 10:58 a.m. Nurse Aide, Employee E2 stated Resident R1 wanted to go to the hospital and when she notified RN, Supervisor, Employee E1 she failed to go in and assess the resident. NA, Employee E2 stated the resident was complaining he hadn't moved his bowels. During an interview on 2/25/26, at 11:07 a.m. LPN, Employee E4 stated if a resident has not had a bowel movement in three days, the bowel protocol would be initiated. It was indicated for residents newly admitted , their last bowel movement is assessed upon admission. Medications for the bowel protocol are automatically put in place upon admission. Staff can also review discharge paperwork to see when a residents last bowel movement was. If a resident has a change in condition, they must be assessed, vitals obtained, and the physician is notified. During an interview on 2/25/26, at 11:09 a.m. LPN, Employee E3 stated she worked 3 p.m. to 11 p.m. on 2/12/26. LPN, Employee E3 was notified Resident R1 wanted to talk with a supervisor and go to the hospital. It was indicated Resident R1 was asking all day. Around 5 p.m. Resident R1 rang his call bell again and requested to see supervisor and go to hospital. RN, Supervisor R1 failed to assess resident and Resident R1 called 911 himself. LPN, Employee E3 stated the resident was having abdomen pain from a bowel obstruction. LPN, Employee E3 stated The resident had an order for citrus magnesium from the other facility, and I don't think he got any of it. Review of Resident R1's Hospital Discharge Summary on 2/25/26, revealed the resident was hospitalized from [DATE], to 2/17/26 for a rectal fecal impaction, severe constipation, requiring oral laxatives, disimpacting and soap suds enema. During an interview on 2/25/26, at 12:27 p.m. the Nursing Home Administrator confirmed that the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of five residents (Resident R1). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services. |