

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  03/25/2026
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, clinical record review, facility submitted documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to prevent elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) for one resident (Resident R1). This failure created an immediate jeopardy situation for 10 of 94 residents assessed by the facility to be at risk for elopement (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, and R10). Findings Include: Review of the facility policy Missing Resident / Elopement Procedures dated 8/8/25, defined elopement: Occurs when a resident leaves a safe area without staff knowledge OR the patient enters an unsafe area without staff knowledge or presence. This can include locations within the building. Review of the clinical record revealed Resident R1 was originally admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 1/31/25, included diagnoses of bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and moyamoya disease (progressive cerebrovascular disorder where the internal carotid arteries narrow, reducing blood flow to the brain and causing strokes, TIAs (mini-strokes), or hemorrhage). Review of Section C: Cognitive Patterns revealed Resident R1 had moderate cognitive impairment. Review of Resident R1's Elopement Risk Assessments completed revealed:9/8/25: Not an elopement risk.10/17/25: Elopement Risk12/27/25: Not an elopement risk. Review of the physician's orders indicated Resident R1 was ordered an electronic monitoring bracelet (electronic bracelet usually worn either on the resident or on their wheelchair that alarms when near doorways connected to the monitoring system) on 2/10/25; and remained a current order. Review of Resident R1's plan of care for Resident exhibits behavior symptoms such as wandering, suicidal ideations initiated 10/22/25, revised on 11/3/25, with the goal of The resident's safety will be maintained and included interventions of:-Check placement of Wanderguard (electronic monitoring bracelet).-Distract resident from wandering by offering pleasant diversions.-Provide a Wanderguard. Review of a progress note dated 3/19/26, 3:45 p.m. At 1545 (3:45 p.m.) writer was informed by activities aide that the resident could not be found post cooking club activity. @1547 (3:47 p.m.) code white was called as resident was not found in any of the nearby rooms or restrooms. After code white was called all employees responded appropriately and were actively searching for resident. @1553 (3:53 p.m.) resident was found outside, in a nearby alley, safely on the berm as to avoid traffic, attempting to go to [NAME] (local convenience store), as she does when she goes on LOAs (leaves of absence) w/ her family. Resident was safely escorted back to facility and up to the third floor where her nurse proceeded to check her vitals and do a head-to-toe assessment assisted by CNA (nurse aide). The LPN (licensed practical nurse) &amp; aide reported directly to writer afterwards, as writer was on the phone w/ [nurse practitioner], and together we informed NP that vital signs are stable, and no skin alterations or injuries were found. Resident was in no distress, had no complaints of pain, but was tearful as she stated, she was not trying to cause any trouble. Additionally stated in this progress note was resident was dressed (continued on next page)</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>appropriately. No new orders were given from NP (nurse practitioner). Writer then called residents RP (responsible party), her mother, to inform her of the incident, there was no answer. Writer then called a second time, still with no answer, and left a message for [Resident R1's mother] to please return call as soon as possible but did inform that the resident was safe. All clear was called @ 1614 (4:14 p.m.). Review of a progress note dated 3/19/26, at 4:20 p.m. indicated, @1600 (4:00 p.m.) resident was escorted back to 3rd floor, able to self-propel in wheelchair to her room, and asked if we could do a head-to-toe assessment as well as vital signs. The resident agreed and the CNA helped writer w/ assessment. Wanderguard noted to be in place on L wrist, and the alarm did sound when resident returned to 3rd floor. Resident alert &amp; oriented x3 w/ no obvious injuries noted. Resident w/ no c/o pain or discomfort but is tearful and feels as though she is in trouble. Writer reassured resident that we are simply happy she is safe, educated resident on the risks of leaving the floor/facility, to which she verbalized understanding. Resident has not had exit seeking behavior this week prior to elopement this evening. Review of an undated employee statement written by Activities Aide Employee E1 indicated, On March 19th I was transporting residents from the 1st floor to 2nd and 3rd. As I was getting them from the dining room to the elevator [Resident R1] had left the 1st floor from sitting at the elevator waiting to go back to her room on 3rd floor. Review of a second undated statement written by Activities Aide Employee E1 indicated, On Thursday March 19th I was taking residents on the elevator back upstairs after an activity. The elevator only holds four people at a time. I had to leave some residents. I dropped the residents off on the third floor. Came back to the first and [Resident R1] was not there, just the other residents. I went to other staff to get help finding her and they found her at [NAME]. She had taken the outdoor elevator. Review of an employee statement dated 3/19/26, Environmental Services (EVS) Employee E2 stated, At approximately 3:30 pm on 3-19-2026 I, [EVS Employee E2], was on the first floor and saw [Resident R1] and another resident but I can't recall whom sitting by the A side elevator, waiting to be taken up from the activity. I walked through the green hallway to retrieve something and came back to the A side to find [Resident R1] gone and assumed she had been taken back to her floor. About 5 minutes later the activities aide, [Employee E1] came back to the elevator asking if I had seen [Resident R1] and instantly we both realize she has managed to make for an exit. I went to the basement first to alert other people to be on the lookout and then ran out of C-side side door to the outside and headed toward family counseling. I then turn right down the alley to go around the building, swing wide into our parking lot to see if I see her and that's when I run into the Dietary supervisor [Employee E3], and the transport coordinator [Employee E4], and I tell them I saw three gentleman around an suv and because I'm a suspicious person, I was worried they loaded her and were blocking her from view. So the three of us head over and politely ask if they'd seen her, per [Employee E4's] less suspicious mind and bless ?em they had seen her and pointed down [NAME]. The three of us begin to sprint because we don't see her in sight still. Halfway down [NAME], in the alley to [NAME], we see [Resident R1], we call out to her and she stops moving. We caught up to her and brought her back to the facility. Review of an employee statement (incorrectly dated 8/19/25), NA Employee E3 stated, I was coming out of the bathroom when the LPN notified me that [Resident R1] was missing. I notified the other aide on the floor and I went to the first floor. I then went outside. When [LPN Employee E4] and I meet we went opposite ways outside. I ask the dietary people if they seen [Resident R1] they said no. Both [LPN Employee E4] and I didn't see her outside. I went to the fourth floor next. I was alerted she was found. When she came back up I helped the LPN Employee E4 with the body check. Review of an employee statement dated 3/19/26, LPN Employee E4 indicated, I was informed by Activities that they could not locate [Resident R1]. I immediately notified my aides and went to notify RN (Registered Nurse) Supervisor. [Employee E3] and I both went outside to look for her and searched inside the building. [Employees E5 and E6] found her. Upon her return all vitals found to be stable and body check was clear. Review of an employee statement dated 3/19/26, Transportation Employee E5 indicated, Announcement went out over intercom stating code white. I went to go look for resident (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>present at the nurse's station. Review of the elopement binder displayed by staff were ten residents documented as an elopement risk (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, and R10). During an interview on 3/23/26, at approximately 3:25 p.m. the Activities Director was asked if the Activities Department had an elopement binder for use by their staff. The Activities Director stated she believed there was one, but did not know where it was. A list of the residents who were at risk for elopement was found and produced at approximately 4:00 p.m. The Nursing Home Administrator was made aware that an Immediate Jeopardy situation existed for residents on 3/23/26, at 4:08 p.m. and a corrective action plan was requested. The Immediate Jeopardy template was provided to the facility administration at 4:09 p.m. The facility plan of correction was accepted on 3/23/26, at 6:30 p.m. to include: The resident was returned to the facility. Full body assessment was completed with no negative findings. Resident is alert and oriented and indicated she just wanted to go to [NAME] where she frequently goes out on Leave of Absence with her family. Physician and family were notified. Resident care plan will be updated to include that resident will be supervised at all times outside of her living unit. Her LOA order already states that she cannot be unsupervised. Immediately, Nursing Home Administrator completed on Elopement/Accidents and Hazards (attached) with Activities Staff that residents coming to the first floor dining room for activities that have a Wanderguard device or deemed at risk for elopement will not be unsupervised at any time, before, during or after the activity until they are returned safely to their respective living area. Immediately, whole house education on Elopement/Accidents and Hazards (attached) was initiated and completed. Elopement assessments were completed on current residents, which are under evaluations in the resident medical chart, elopement binders were verified for accuracy and completion. Activities on the first floor will be continued; however, the following plan has been implemented to ensure resident safety and decreased risk of elopement: Facility leadership, including Social Services Director, admission Director, Human Resources Director, LPN Unit Manager, Infection Preventionist, Business Office Manager, Appointment Scheduler, Staff Scheduler, Director of Rehabilitation, Medical Records, and Maintenance Director will assist during large group activities planned for the first floor dining room to ensure direct supervision support. Leadership will support activities staff in transporting residents to/from first floor dining room where the activity is taking place as well as provided additional supervision during the activity. Activity Director will verbalize the need for help in morning standup meeting as well as provide a sign-up sheet for leadership to secure. At no time will residents with Wanderguard device or residents at risk of elopement be left unsupervised. 4 people will be needed: one in room, one transporting in the hallway, one transporting the elevator, and one observing the hallway. Facility has reduced the number of activities in the first-floor dining room to the larger, primary activities such as auction, birthday party, cooking club, special events. Once all residents are in the dining room on first floor, the door will be closed. A bell has been placed on the door to alert staff if someone is attempting to open the door. Other activities will be modified to be completed on the resident floors in the dayrooms. Activities such as Church and Resident Council that are smaller integrated activities, will be scheduled in the 3A dayroom moving forward. New residents admitting will be evaluated for elopement. Discussion of findings will occur during the morning meeting process. If resident is deemed an elopement risk, elopement binders will be updated, Wanderguard will be placed, and interdisciplinary team will all be made aware for resident safety. Audits of group activities occurring in the first-floor dining room will be completed by Nursing Home Administrator for proper supervision of residents twice per week for two weeks, then once per week for two weeks, then weekly for two months. here have been no large group activities since the date of this occurrence to audit. Audits will begin with the next large group activity. All education, updates to care plan, modifications to activities will be completed by Wednesday, 03/25/2026. Audits will begin with next large group activity, scheduled for Wednesday 03/25/2026. Review of Resident R1's clinical record confirmed that Resident R1's responsible party and the nurse practitioner were notified on 3/19/26, at 3:45 p.m. and new interventions were placed in the plan of care. Review of clinical records on (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3/24/26, confirmed the facility completed whole-house education to 116 of 116 staff members. A total of 98 of 116 confirmed education via signing the education in-service sheet. 20 of 116 staff members were educated via phone. 2 of 20 have returned to the facility and signed in-service sheet prior to the start of their shift. All other staff members will be required to verify they were educated via signing the in-service education sheet prior to the start of their next shift. During in-person interviews conducted on 3/24/26, 34 of 34 verified they were educated on the elopement procedure and to not leave residents unsupervised. Review of education documents indicated that on 3/19/26, the Nursing Home Administrator educated the activity staff members that when residents are brought to activities on the first floor from the third floor, at no time during the activity or after the activity should these residents be unattended. This includes when residents are transported to/from the elevator to go to the dining room and accompanied by activities staff to ensure their safety. During 32 staff interviews completed on 3/24/26, beginning at approximately 9:45 a.m. confirmed all staff had received education on elopement prevention and actions to take if a resident leaves the facility. During an interview on 3/25/26, at approximately 10:00 a.m. the Activities Director was asked if Activities staff had previously been provided education on ensuring the safety of residents at risk for elopement, to which she responded, Not really, probably during orientation. During observations on 3/24/26, the elopement binders were confirmed to be updated as of 1:00 p.m. Review confirmed that 94/94 elopement assessments were completed. 10/94 residents were identified at risk for elopement. The Immediate Jeopardy was removed on 3/24/26, at 2:56 p.m. when the action plan implementation was verified. During an interview on 3/25/25, at approximately 1:00 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision to prevent elopement for one of two residents left unsupervised. This failure created an immediate jeopardy situation for 10 of 94 residents assessed by the facility to be at risk for elopement. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(e)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa Code 211.12(d)(1)(2)(5) Nursing services.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>Based on review of the facility's job descriptions, employee attendance information, and staff interviews, it was determined that the facility failed to ensure the consistent services of a full-time Director of Nursing (35 or more hours a week) in the facility. Review of the facility provided Director of Nursing (DON) job description, undated, indicated that the DON position purpose was, Planning, organizing, developing, and directing the overall operations of the Nursing Service Department in accordance with local, state, and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents. Included in the listing of Required Qualifications was Current unrestricted license as a Registered Nurse in practicing state. Information reported to the State Department of Health indicated that Registered Nurse Employee E1 started as the DON for the facility on 1/15/26. Review of facility provided Stand-Up sheets 2/2/26, through 3/23/26, failed to include documentation that the DON was present and acting in the capacity as Director of Nursing on 23 of 36 business days: Monday, 2/2/26: The DON was documented as not present in the building. Tuesday, 2/3/26: Stand-Up sheet not signed by the DON, unknown if present. Wednesday, 2/4/26: Stand-Up sheet not signed by the DON, unknown if present. Thursday, 2/5/26: The DON was documented as not present in the building. Friday, 2/6/26: The DON was documented as not present in the building. Monday, 2/9/26: The DON was documented as present in the building. Tuesday, 2/10/26: The DON was documented as not present in the building. Wednesday, 2/11/26: The DON was documented as not present in the building. Thursday, 2/12/26: The DON was documented as not present in the building. Friday, 2/13/26: The DON was documented as not present in the building. Monday, 2/16/26: The DON was documented as present in the building. Tuesday, 2/17/26: The DON was documented as present in the building. Wednesday, 2/18/26: The DON was documented as present in the building. Thursday, 2/19/26: The DON was documented as present in the building. Friday, 2/20/26: The DON was documented as not present in the building. Monday, 2/23/26: No Stand-Up sheet available. Tuesday, 2/24/26: The DON was documented as present in the building. Wednesday, 2/25/26: No Stand-Up sheet available. Thursday, 2/26/26: No Stand-Up sheet available. Friday, 2/27/26: No Stand-Up sheet available. Monday, 3/2/26: The DON was documented as present in the building. Tuesday, 3/3/26: The DON was documented as not present in the building. Wednesday, 3/4/26: The DON was documented as present in the building. Thursday, 3/5/26: Stand-Up sheet not signed by the DON, unknown if present. Friday, 3/6/26: The DON was documented as present in the building. Monday, 3/9/26: The DON was documented as not present in the building. Tuesday, 3/10/26: DON documented as arriving late. Wednesday, 3/11/26: Stand-Up sheet not signed by the DON, unknown if present. Thursday, 3/12/26: The DON was documented as present in the building. Friday, 3/13/26: No Stand-Up sheet available. Monday, 3/16/26: The DON was documented as not present in the building. Tuesday, 3/17/26: The DON was documented as not present in the building. Wednesday, 3/18/26: No Stand-Up sheet available. Thursday, 3/19/26: The DON was documented as not present in the building. Friday, 3/20/26: The DON was documented as not present in the building. Monday, 3/23/26: The DON was documented as not present in the building. Two additional Stand-Up sheets were present, undated, both documented that the DON was not present in the facility. Review of facility-provided employment information, the Assistant Director of Nursing had a final employment date of 2/16/26. Thereafter, no additional registered nurse was placed in an Interim Director of Nursing Position. During an interview on 3/23/26, at approximately 10:30 a.m. the Nursing Home Administrator confirmed that the DON was not currently in the building and was using paid time off through her last day of employment on 3/24/26. During an interview with the Nursing Home Administrator on 3/25/26, at approximately 1:15 p.m. confirmed that there was no documented evidence that Registered Nurse Employee E1 worked 35 or more hours a week in the (continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>Based on review of job descriptions, clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed effectively manage the facility to protect residents from elopement. This failure resulted in a resident, who was a known elopement risk, exiting the building unsupervised (Resident R1). This failure created an Immediate Jeopardy situation for 10 of 94 residents who were documented as elopement risks (Resident R1, R2, R3, R4, R5, R6, R7, R8, R9, and R10). Findings include: Review of the facility-provided Nursing Home Administrator (NHA) job description indicated, Leads, guides and directs the operations of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care. Review of the facility-provided Director of Nursing (DON) job description indicated, Planning, organizing, developing and directing the overall operations of the Nursing Service Department in accordance with local, state and federal standards and regulations, established facility policies and procedures and as may be directed by the Administrator and the Medical Director, to provide appropriate care and services to the residents. Based on findings identified in this report, the facility failed to prevent the failed protect residents from exiting the facility unsupervised. The NHA and the previously employed DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 3/25/26, at approximately 12:30 p.m. the NHA and current DON confirmed that facility administration failed effectively manage the facility to protect residents from elopement. This failure resulted in a resident, who was a known elopement risk, exiting the building unsupervised. This failure created an Immediate Jeopardy situation for 10 of 94 residents who were documented as elopement risks. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		