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	06/09/2026

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 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 interviews it was determined that the facility failed to protect resident from sexual abuse for one of three residents (Resident R3).Findings include: Review of facility's Abuse, Neglect, and Exploitation policy dated 4/27/26, stated it is the facility policy to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse. Sexual abuse is defines as non-consensual sexual conduct of any type with a resident. Review of Residents R1's admission record indicated the resident was admitted on [DATE], with diagnoses of metabolic encephalopathy, intellectual disabilities, and paraphilias (intense persistent sexual interests, urges or fantasies involving atypical objects, situations, or non-consenting partners). Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/12/26, indicated diagnoses were current. Section C-Cognitive Patterns revealed the resident is rarely/never understood. Review of Resident R1's care plan dated 4/13/23, indicated the resident was care planned for agitation and discussing masturbation with roommate. On 1/14/25, it was revised for the resident inappropriate touching. Interventions included to administer medications as ordered, redirect to stay out of others rooms, stop sign has been placed on door way of frequently approached room. Review of Residents R3's admission record indicated the resident was admitted on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/25/26, indicated diagnoses of anxiety, depression, and mild intellectual disabilities. Section C-Cognitive Patterns revealed the resident is rarely/never understood. Review of information submitted to the State Agency on 5/21/26, by the Director of Nursing revealed on 5/21/26, it was reported a resident (Resident R2) witnessed Resident R1 touching up and down the front of Resident R3's blouse. Resident R2 yelled at Resident R1 to stop and the alleged perpetrator started to yell and make mean faces, then left the dayroom. Review of Resident R2's witness statement dated 5/21/26, stated I witnessed Resident R1 touching Resident R3 up and down the front of her shift. I told him to stop and to get away and he started yelling at me. Resident R1 was making mean faces like he wanted to fight saying what am I talking about. Review of Licensed Practical Nurse (LPN) Infection Preventionist (IP), Employee E1 witness statement stated they were alerted by Resident R2 that Resident R1 touched Resident R3 inappropriately. Resident R1 exited room after she told him to stop. LPN, Employee E1 went to dayroom and Resident R1 was not in the day room. It was indicated the Registered Nurse, Supervisor was alerted. Review of Resident R4's undated witness statement completed by Assistant Director of Nursing (ADON), Employee E2 revealed per verbal in-person interview Resident R4 heard her say stop it once then two to three times more. During an interview on 6/9/26, 10:59 a.m. Resident R4 stated on 5/21/26, he heard Resident R2 yelling at Resident R1 to stop, however Resident R1 does not understand much. Resident R4 stated he heard her yelling for about five minutes and she told staff about the incident. During an attempted interview on 6/9/26, at 11:05 a.m. Resident R2 was out of the facility and unavailable. During an interview on 6/9/26, at 12:19 p.m. Registered Nurse (RN) Supervisor, Employee E3 confirmed she was present when the incident between Resident R1 and (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R3 occurred on 5/21/26. RN Supervisor stated she was unsure who alerted her of the incident, but stated it occurred after 3 p.m. and since the Director of nursing was still in the building she took charge. It was indicated Resident R1 went back to his room and checks were completed every 15 minutes. During an interview on 6/10/26, at 12:23 p.m. Licensed Practical nurse (LPN), Employee E4 stated she was assigned on the unit on 5/21/26, when the incident between Resident R1 and Resident R3 occurred. It was indicated the incident occurred during the 7 a.m. to 3 p.m. shift. LPN, Employee E4 indicated she was not present in dayroom when it happened, but Resident R3 approached her and stated Resident R1 had his hands on the outside of Resident R3's shirt. Resident R3 told Resident R1 to stop, and he did it more than once. LPN, Employee E4 then alerted the RN Supervisor and administration. Resident R1 was placed on every 15 minute checks and Resident R3 was assessed. During an attempted interview on 6/9/26, at 2:20 p.m. Resident R2 was out of the facility and unavailable. During an interview on 5/20/26, at approximately 2:30 p.m. the Director of Nursing confirmed the facility failed to protect resident from sexual abuse for one of three residents (Resident R3). 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 211.10 (a) (d) Resident care policies

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility documents, facility policy, clinical records, and staff and resident interviews, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse for one of three residents (Resident R3).Findings include: Review of facility's Abuse, Neglect, and Exploitation policy dated 4/27/26, stated it is the facility policy to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse. Sexual abuse is defines as non-consensual sexual conduct of any type with a resident. The facility will identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The facility must provide complete and through documentation of the investigation. Review of the facility's Resident Accidents and Incidents policy dated 4/27/26, indicated it is the facility policy to ensure all incidents involving a resident a reported, documented and investigation initiated after the incident is identified. The nursing supervisor immediately notified of incidents. Statements must be obtained at the time incident is identified and should include pertinent information such as witnessed details of event, last time employee provided care or saw resident, resident's status/behavior when last seen prior to event, any additional facts pertinent to the extent and contributing factors resulting in the event. Review of information submitted to the State Agency on 5/21/26, by the Director of Nursing revealed on 5/21/26, at 4:00 p.m. it was reported Resident R2 (Brief Interview Mental Status (BIMS) Score of 15/15, cognitively intact) witnessed Resident R1 touching up and down the front of Resident R3's blouse while in the dayroom on the second floor. Resident R2 yelled at Resident R1 to stop and the alleged perpetrator started to yell and make mean faces, then left the dayroom. Review of the facility's documentation for mandatory abuse reporting revealed the incident occurred on 5/21/26, at 3:30 p.m. Review of the facility's assignment sheet for 5/21/26, revealed Registered Nurse Supervisor, Employee E3 was the facility's RN Supervisor for the day and evening shift from 7 a.m. to 7 p.m. Licensed Practical Nurse (LPN), Employee E4 was the floor nurse on 2AB from 7 a.m. to 3 p.m. Review of the facility's investigation dated 5/21/26, revealed a copy of a police statement signed by the Director of Nursing (DON) indicated Resident R2 stated that she witnessed resident R1 touching Resident R3 up and down the front of her blouse. Resident R3 stated that she told Resident R1 to stop then Resident R1 started to yell at her, but he left the dayroom at that time. Resident R2 reported to the charge nurse, LPN, Employee E4. Review of Nurse Aide (NA), Employee E5 undated and unsigned witness statement completed by ADON, Employee E2 stated per verbal phone interview it was indicated NA, Employee E5 was not aware of the situation. The facility failed to obtain signed witness statements from the witness. Review of Resident R4's undated witness statement completed by Assistant Director of Nursing (ADON), Employee E2 revealed per verbal in-person interview Resident R4 heard Resident R2 say stop it once then two to three times more. The facility failed to obtain signed witness statements from the witness. During an interview on 6/9/26, at 11:18 a.m. the Director of Nursing (DON) stated she was present in the facility when the incident between Resident R1 and Resident R3 occurred on 5/21/26, in the dayroom. The DON stated when an incident happens, I always come in, I always run it. The Director of nursing stated she obtained witness statements. The DON stated she would have to ask the Assistant Director of Nursing when verbal and phone interviews were completed. The DON confirmed the facility failed to obtain signed and dated witness statements for Resident R4 and NA, Employee E5. During a phone interview on 6/9/26, at 12:04 p.m. NA, Employee E5 confirmed she was not present when the incident between Resident R1 and Resident R3 occurred. Review of LPN, Infection Preventionist (IP), Employee E1 signed witness statement dated 5/21/26, stated they were alerted by Resident R2 that Resident R1 touched Resident R3 inappropriately. Resident R1 exited room after she told him to stop. LPN, Employee E1 went to dayroom and Resident R1 was not in the day room. It was indicated the Registered Nurse, Supervisor was alerted. During a phone interview on 6/9/26, at 12:10 p.m. IP, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employee E1 stated she was not involved with the incident that occurred on 5/21/26, between Resident R1 and Resident R3. She stated the daylight nurse was more involved and she did not work until 3 p.m. to 11 p.m. LPN, IP, Employee E1 stated I did not complete a witness statement. It was indicated LPN, Employee E4 was the nurse present when it occurred. During an interview on 6/9/26, at 12:19 p.m. Registered Nurse (RN) Supervisor, Employee E3 confirmed she was present when the incident between Resident R1 and Resident R3 occurred on 5/21/26. RN Supervisor, Employee E3 stated she was unsure who alerted her of the incident, but since the Director of Nursing was still in the building she took charge. RN, Supervisor, Employee E3 confirmed she did not complete a witness statement. During an interview on 6/9/26, at 12:23 p.m. LPN, Employee E4 stated on 5/21/26, she was the floor nurse on the unit when the incident between Resident R1 and Resident R3 occurred. It was indicated the incident occurred during the 7 a.m. to 3 p.m. shift. LPN, Employee E4 stated she was not present in dayroom when it happened, but Resident R3 approached her and stated Resident R1 had his hands on the outside of Resident R3's shirt. Resident R3 told Resident R1 to stop, and he did it more than once. LPN, Employee E4 then alerted the RN Supervisor and Director of Nursing and Nursing Home Administrator. LPN, Employee E4 confirmed she did not complete a witness statement. Review of the facility's investigation failed to include witness statements from RN, Supervisor Employee E3 and LPN, Employee E4. During an interview on 5/20/26, at 2:26 p.m. the Director of nursing confirmed that the facility failed to conduct a thorough investigation, and obtain all witness statements for one of three residents (Resident R3). 28 Pa Code: 201.29 (a)(c) Resident Rights.28 Pa Code: 211.12 (c)(d)(1)(3)(5) Nursing services.

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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 facility policy, clinical record review and staff interview, it was determined that the facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status for one of three residents reviewed (Resident R1).Findings Include: Review of the facility's Resident Accidents and Incidents policy dated 4/27/26, indicated it is the facility policy to ensure all incidents involving a resident a reported, documented and investigation initiated after the incident is identified. The nursing supervisor immediately notified of incidents. The resident's care plan is updated by the assigned Nurse, Clinical Manager, or Nursing Supervisor. The clinical manager or assigned nurse will ensure the resident care plan is updated with any new interventions identified during clinical rounds. Review of Residents R1's admission record indicated the resident was admitted on [DATE], with diagnoses of metabolic encephalopathy, intellectual disabilities, and paraphilias (intense persistent sexual interests, urges or fantasies involving atypical objects, situations, or non-consenting partners). Review of Resident R1's care plan dated 4/13/23, indicated the resident was care planned for agitation and discussing masturbation with roommate. On 1/14/25, it was revised for the resident inappropriate touching. Interventions included to administer medications as ordered, redirect to stay out of others rooms, stop sign has been placed on door way of frequently approached room. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/12/26, indicated diagnoses were current. Review of information submitted to the State Agency on 5/21/26, by the Director of Nursing revealed on 5/21/26, it was reported a resident (Resident R2) witnessed Resident R1 touching up and down the front of Resident R3's blouse. Resident R2 yelled at Resident R1 to stop and the alleged perpetrator started to yell and make mean faces, then left the dayroom. Review of Resident R1's care plan revised on 5/22/26, revealed the resident likes to be naked and interventions included the resident was seen by psych services on 5/22/26. The care plan failed to include a revision that addressed the inappropriate touching and interventions to prevent reoccurrence. The facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status. Review of information resubmitted to the State Agency on 5/23/26, by the Director of Nursing, revealed the interdisciplinary team met and reviewed care plan and interventions. Staff education to round very frequently and check on residents in the day rooms on all units. Physicians and responsible parties were notified and in agreement with interventions and care plan updated. Review of Resident R1's physician order dated 5/24/26, indicated to observe frequently when in dayroom, assure rounding frequently. Review of Resident R1's care plan initiated on 5/26/26, a total of five days after incident, stated 5/24/26 observed frequently when in dayroom; assure rounding as per orders. The facility failed to ensure the care plan was reviewed and revised to accurately and timely to reflect the resident's current status. During a phone interview on 6/9/26, at 12:41 p.m. the Registered Nurse Assessment Coordinator (RNAC), Employee E6 stated it is expected revisions of care plans are made as soon as changes are made. RNAC, Employee E6 stated resident's care plan should be reflective of what is currently going on. During an interview on 6/9/26, at 2:30 PM, the Director of Nursing the facility failed to ensure that the care plan was reviewed and revised to reflect the resident's current status for one of three residents reviewed (Resident R1). 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services