

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R2).</p> <p>Findings include:</p> <p>Review of facility policy Resident Communication System and Call Light Policy dated 1/2/24, indicated when the resident is in bed or confined to a chair, be sure the call light is within easy reach.</p> <p>Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]/24.</p> <p>Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/6/24, indicated diagnoses of high blood pressure, anemia (too little iron in the blood), and Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking).</p> <p>During an observation on 9/11/24, at 11:14 a.m. Resident R2 was observed sitting on the edge of her bed. During this observation, Resident R2 stated, I'm not supposed to get up on my own, but how do they expect me to call for help when my call bell is on the floor? At this time, Resident R2's call bell was noted to be on the floor between her bed and her recliner.</p> <p>During an interview on 9/11/24, at 11:16 p.m. Nurse Aide Employee E2 confirmed that Resident R2's call bell was not accessible and unavailable for use to the resident.</p> <p>During an interview on 9/13/24, at 11:20 a.m. the Director of Nursing confirmed that the facility failed to accommodate the call bell needs for one of five residents as required.</p> <p>28 Pa. Code: 201.29(j) Resident rights.</p> <p>28 Pa. Code: 211.10(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(3)(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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of clinical records and staff interview, it was determined that the facility failed to notify the family of a change in condition in a timely manner for one of three residents (Resident R37).</p> <p>Findings include:</p> <p>Review of facility policy Resident Change in Condition, dated 1/2/24, indicated that the physician and Resident/Family/ Responsible Party will be notified when there has been a significant change in the resident's physical/emotional/mental conditions, and a need to alter the resident's medical treatment, including a change in provider orders.</p> <p>Review of the clinical record revealed that Resident 37 was admitted to the facility on [DATE].</p> <p>Review of Resident 37's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/27/24, indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and chronic pain syndrome.</p> <p>Review of a Resident Representative concern dated 9/4/24, indicated that the Resident Representative was granted guardianship of Resident R37. Resident R37 had informed her Resident Representative that she was going out for a scope, but that no one from the facility had informed the Resident Representative why this was occurring, and when it was to occur, and that she had not given consent for the procedure.</p> <p>During an interview on 9/10/24, at 11:53 a.m. Nursing Home Administrator confirmed that he was aware that the Resident Representative was made legal guardian of Resident R37 as he had attended the court proceeding that granted the Resident Representative guardianship.</p> <p>During an interview on 9/10/24, at 2:35 p.m. Scheduler Employee E4 stated that she had made the appointment for Resident R37 at the Gastroenterologist (a doctor that specializes in the treatment of all organs involved in the digestive system), after she was informed by Speech Therapist Employee E5, that Resident R37 had a change in her swallowing condition.</p> <p>During an interview on 9/10/24, at 2:41 p.m. Scheduler Employee E4 confirmed that the facility failed to document that the Resident Representative was made aware of the need for the appointment or that it was scheduled.</p> <p>During an interview on 9/12/24, at 9:33 a.m. Speech Therapist Employee E5 confirmed that the Resident R37 had a history of difficulty swallowing and that she required her esophagus (a muscular tube that moves food from the mouth to the stomach) to be stretched occasionally to allow ease in swallowing. Speech Therapist Employee E5 stated that Resident R37 had recent complaints of her ability to swallow comfortably.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24, at 2:12 p.m. Director of Nursing confirmed that the facility failed to notify Resident R37's Resident Representative of the change in Resident R37's swallowing condition and that Resident R37 was to go out of the facility for a procedure.</p> <p>28 Pa. Code: 201.29(a)(b)(c)(d)(j)(m) Resident rights.</p> <p>28 Pa. Code: 201.14(a)(c)(d)(e) Responsibility of licensee.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28. Pa. Code: 211.10(a)(c)(d) Resident care policies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for one of three residents (Resident R38).</p> <p>Findings include:</p> <p>Review of facility policy Comprehensive Care Planning dated 1/2/24, indicated that the facility must develop a comprehensive Person-Centered Care Plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Review of Resident R38's admission record indicated he was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/7/24, included diagnoses of bipolar disorder (a mental condition marked by alternating periods of elation and depression), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and unspecified intellectual disability (an intellectual disability given to people over the age of five that cannot be assessed using standardized testing).</p> <p>Review of the clinical record revealed a diagnoses list that indicated that Resident R38 had a history of suicidal ideations (thinking about or planning suicide).</p> <p>Review of Resident R38's plan of care conducted on 9/11/24, failed to include goals and interventions related to suicidal ideations.</p> <p>During an interview on 9/12/24, at 9:53 a.m. Director of Nursing confirmed that the facility failed to develop and implement comprehensive care plans to meet resident care needs for one of three residents.</p> <p>28 Pa. Code 211.11(d) Resident care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility documents, facility policy, clinical records, facility tour, resident interview, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (leaving an area without permission) for one of 11 residents (Resident R38).</p> <p>Findings include:</p> <p>Review of facility policy Elopement/Unauthorized Absence last reviewed 8/2/24, indicated that the facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner.</p> <p>All residents will be assessed for the risk of elopement using the Elopement Observation on admission, quarterly, and as needed. Residents identified at risk will have interventions promptly implemented to reduce the risk of elopement.</p> <p>Resident elopement/unauthorized absence procedure includes but is not limited to the following:</p> <p>Actions when resident is located: Initiate prompt interventions to prevent further exit seeking.</p> <p>Review of Resident R38's admission record indicated he was admitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 8/7/24, included diagnoses of bipolar disorder (a mental condition marked by alternating periods of elation and depression), schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and unspecified intellectual disability (an intellectual disability given to people over the age of five that cannot be assessed using standardized testing).</p> <p>Review of clinical record revealed that on 9/27/23, Resident R38's care plan included interventions of Resident will be monitored to minimize risk of wandering/and or elopement.</p> <p>Review of clinical record revealed that on 9/29/23, a physician's order was written for Resident R38 to receive a Wanderguard (a device applied to the resident that alerts staff when they leave a safe area).</p> <p>Review of clinical record revealed a psychiatric diagnostic evaluation dated 8/9/24, that stated Resident R38 Always states he wants to go to the psych unit which is his usual. Lately he expresses suicidal ideations (thinking about or planning suicide) to go to inpatient psych but then denies a plan once there and is happy to be given a cheeseburger and fries. Staff report this is a behavior which is rewarded by getting food, so he continues to ask to go to the psych unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility document [NAME] Locks/Wanderguard dated 8/30/24, indicated that the Wanderguard system was evaluated and found to be in working condition.</p> <p>Review of documentation provided by the facility on 8/31/24 included the following: Resident R38 was located outside the facility at around 7:15a.m and brought back in the facility without incident. The resident was sitting in his wheelchair under the facility canopy next to the building. The resident was not injured and had on moccasins a t-shirt and sweat pants and it was 72 degrees for this location. He was only outside for a few minutes. Resident R38 was located outside at 8:05am being seen by staff and another resident and was brought back into the facility without incident. The resident was in moccasins a t-shirt and sweat pants and it was 72 degrees for this location. The resident did have another wander guard module applied and disguised with black tape to his w/c, so it is out of mind so he would not cut if off and a Wander Guard was applied to his left wrist at 10am when he allowed a staff member to apply it. The resident was assessed by the RN (registered nurse) head-to-toes after each occurrence. The investigation on how the resident was outside is on-going and once the root cause is determined we will mitigate these causative factors to keep this resident as well as all residents safe. The resident was assessed for each occurrence and found to be at his baseline. The resident was assessed to be an elopement risk, the magnetic door lock was not engaged, and the resident wheeled his self out at 8:05 am after pushing the button for the automatic doors. The second occasion the resident was sitting at the main entrance and a family member decoded the door and Resident R38 was in his wheelchair and went out the main entrance door as the visitor watched him wheel by to the sidewalk under the canopy and sit in his wheelchair. The facility will place signs to all who enter to not let residents/anyone out when entering/exiting the facility Main Entrance doors. The resident cut off his wander guard off his wheelchair with a butter knife.</p> <p>Review of clinical record revealed a progress note dated 8/31/24, at 7:40 a.m. from RN Supervisor Employee E11 that stated the following: RN Supervisor was alerted by 11-7 staff at 7:30 a.m. who were going home that Resident R38 was sitting on the front sidewalk in his wheelchair and was refusing to come back inside the building. RN supervisor approached Resident R38 and he yelled that he wanted to go to the psych ward. RN stated that at this time he needed to come back inside, and he stated that if anyone came near him, he would punch them. RN stated importance of coming inside to get cleaned up as he was wet with urine and Resident R38 stated that he didn't care. An aide and RN cautiously unlocked the wheelchair brakes and attempted to move wheelchair forward but Resident R38 planted his feet so RN could not propel the wheelchair. RN pulled wheelchair backwards into the building and continued our conversation in the courtyard as he wanted fresh air and sunshine. Then escorted to his room for provision of incontinence care and to eat his breakfast. There were no signs of injuries. An aide retrieved the cut off wander guard from the floor of his room and gave it to RN. RN asked Resident R38 if he took the Wanderguard off of his wheelchair and he confirmed, then asked how he got the Wanderguard off, and Resident R38 stated that he took a butter knife off of the breakfast cart and cut the band off . Threatened the RN to never place another Wanderguard on his wheelchair ever again. He was wearing a t-shirt, red sweat pants, socks, and brown moccasin type slippers. RN ensured the front doors were securely locked in prevention of future elopement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of clinical record revealed a progress note dated 8/31/24, at 9:00 a.m. from RN Supervisor Employee E11 that stated the following: Nurse aide (NA) came running to nurse's station to alert RN that Resident R38 was climbing up the bank across from room [ROOM NUMBER]. Resident of 223 said to NA, 'Who is that man climbing up the bank?' NA looked out the window, recognized the resident, and alerted RN. We ran outside and found Resident R38 sitting between two American Arborvitae (a type of tree) at the top of a 45 degree bank/hill where the mulch met the grass. His appearance was somber. Asked him how he got outside, and he said a delivery man let him out and then pointed to a visitor's truck. The Wanderguard had been reapplied to the w/c since the previous elopement and was tested to confirm functionality. We guided him down the bank as he scootched along to the bottom and we assisted him to a standing position. Another aide came outside to see how we were doing and brought us a wheelchair upon request. His legs appeared to be shaky as he stood mere seconds waiting to be seated. No injuries were noted although there was dirt on the seat and left knee/shin area of his sweatpants. He was wearing a t-shirt, sweatpants, socks, and moccasin slippers. Wheelchair was noted to be sitting on the sidewalk outside an office window next to the wall. We escorted Resident R38 into the facility to the shower room where the aide provided him with a shower. Again, no injuries were noted. Stated he wants sent to the psych ward and to 'keep that fuckin' nurse away from' him. He was designated a 1:1 (one-on-one) sitter without further incident.</p> <p>Review of clinical record revealed a progress note dated 8/31/24, at 7:41 p.m. that stated, No orders per doctor to transfer Resident R38 to hospital.</p> <p>During an observation and interview on 9/11/24, at 12:20 p.m. Resident R38 was noted to be in room with one-on-one supervision from staff. Resident stated that he was in a good mood because I have pop, chips and candy.</p> <p>During an interview on 9/11/24, at 12:20 p.m. Central Supply Employee E10 stated that staff have been accommodating with Resident R38's snack requests as this appears to make Resident R38 content.</p> <p>During an interview on 9/11/24, at 1:28 p.m. DON stated after the first elopement on 8/31/24, and prior to second elopement on 8/31/24, staff reapplied the Wanderguard onto Resident R38's wheelchair and attempted to camouflage it with black tape so that he Resident R38 would not notice it., and also immediately started educating staff on proper elopement procedures.</p> <p>During an interview on 9/11/24, at 2:25 p.m. RN Employee E12 stated that One-on-one (supervision) started on the day of elopement. I came in at noon and he had one on one at the desk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/12/24, at 1:41 p.m. RN Supervisor Employee E11 confirmed that she was the supervisor at the time of Resident R38's elopements on 8/31/24, and worked the 7:00 a.m. to 3:00 p.m. shift. RN Supervisor Employee E11 stated that night shift was leaving when they noticed him outside on the sidewalk. One staff member stayed with Resident R38 and an additional employee came into the building requesting help from RN Supervisor Employee E11 to assist in bringing Resident R38 back into the building. She was unaware of how long he had been out of building. RN Supervisor Employee E11 stated after the first elopement I made sure the doors were secured and locked, and brought him into building. He (Resident R38) told me he wanted to sit outside in the sunshine and talk, so I took him out into the courtyard (an enclosed area) and sat and talked with him for about five or ten minutes, until I got him to agree to go in and eat breakfast. RN Supervisor Employee E11 stated that she then went to another unit to work until she was alerted by staff that Resident R38 was seen outside again. RN Supervisor Employee E11 stated that when she went outside, Resident R38's wheelchair was on the sidewalk, and Resident R38 was on the hillside as he is able to walk unassisted. When asked if the Wanderguard was on the wheelchair, RN Supervisor stated that she Wasn't sure and He keeps taking it off. He (Resident R38) used to have it on his wrist or ankle, but he kept taking them off. When asked how Resident R38 was able to get out of the building a second time, RN Supervisor Employee E11 stated that Resident R38 got a visitor to hold the door for him. RN Supervisor Employee E11 stated that Resident R38 now receives one on one supervision as a result of his repeated elopements.</p> <p>During a tour of the facility grounds on 9/13/24, at 10:30 a.m. the location of where Resident R38 was located after his second elopement was found to be approximately 20-30 yards from the front entrance, and the hillside was approximately at a 45-degree angle and approximately ten feet long. It was also noted that a sign is posted on the door alerting visitors to let residents out of the door without permission.</p> <p>During an observation on 9/13/24, at 11:00 a.m. Resident R38 was seen in his room with one-on-one supervision, as staff was ordering him a pizza for lunch. Resident R38 was noted to have Wanderguard applied to his left wrist, which he enthusiastically displayed as staff had put his initials on it with a smiley face.</p> <p>During an interview on 9/13/24, at 12:05 p.m. Licensed Practical Nurse (LPN) Employee E13 stated that she was present on 8/31/24, when Resident R38 eloped and that no Wanderguard alarm went off during either elopement. I would have been able to hear it because I was in the Front Hall (by the Main Entrance), and it is very loud. LPN Employee E13 also added that Resident R38 appears to be Much more content with one on one (supervision).</p> <p>During an interview on 9/13/24, at 12:29 p.m. Maintenance Director Employee E14 confirmed that the Wanderguard system is tested by his department daily to ensure that it is working properly, and that the Door Company has come in to ensure that the doors are latching properly.</p> <p>During an interview on 9/13/24, at 2:02 p.m. Nursing Home Administrator confirmed that the facility failed to provide adequate supervision which resulted in two elopements for Resident R38.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>48546</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 prevent the development and transmission of a communicable infection.</p> <p>Findings include:</p> <p>The job description for the Nursing Home Administrator specified the primary purpose of the job is to lead, direct, and manage the overall operations of the community in accordance with policies and procedures and current federal, state and local standards, guidelines and regulations that govern the community and to ensure the highest degree of quality care is maintained for each resident at all times.</p> <p>The job description for the Director of Nursing specified it is the responsibility of the DON to organize, develop, manage, and direct the overall operations of the Nursing Service Department in accordance with current federal, state and local standards, guidelines and regulations that govern the community. The DON is to work directly with the NHA and the Medical Director to ensure the highest degree of quality of care is maintained for each resident at all times.</p> <p>Based on findings identified in this report, the facility failed to prevent the transmission of COVID-19 for 34 residents, which placed the residents in an Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed.</p> <p>During an interview on 9/13/24, at 11:00 a.m. the NHA and DON confirmed that they failed to effectively manage the facility to prevent the development and transmission of a communicable infection.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p> <p>28 Pa. Code 207.2 (a) Administrator's responsibility.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policies and documentation, observations, and staff interviews, it was determined that the facility failed to maintain an infection prevention and control program by failing to follow infection control guidelines from the Centers for Disease Control (CDC) and the Pennsylvania Department of Health (PA DOH) to reduce the spread of infections and prevent cross-contamination during a COVID-19 outbreak. The facility failed to perform contact tracing and testing per PA DOH guidelines and cohorted (an infection prevention and control strategy of grouping residents together who are identified with the same organism to confine their care to one area and prevent contact and spread to other residents) residents who were positive for COVID-19 with residents who were not tested and did not have symptoms of COVID-19. This failure placed the facility in an Immediate Jeopardy situation for 35 of 47 residents reviewed (Residents R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, and R35).</p> <p>Review of the Pennsylvania Department of Health COVID-19 Infection Control and Outbreak Response Toolkit for Long-Term Care Version 1.1 dated February 2024, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities revealed the following:</p> <p>During the Outbreak: COVID-19 Outbreak Management and Control Measures included:</p> <ol style="list-style-type: none"> 1. Identify and Isolate First Case. <ol style="list-style-type: none"> a. Isolate with transmission-based precautions (TBP) on COVID-19 Care Unit in accordance with most up-to-date isolation guidance or provide source control to positive resident and isolate in room (ideally residents should be placed in a single-person room). b. Place TBP signs on the door to indicate to those entering the COVID-19 Care Unit/room of the personal protective equipment (PPE) requirements when providing care to residents with COVID-19. c. Ensure all required PPE is available including N95 or higher-level respirator, gowns, gloves, and eye protection and is worn. d. Reinforce core infection prevention practices among residents, visitors, and healthcare personnel (HCP) including hand hygiene, appropriate use of PPE, environmental cleaning, and disinfection. 2. Identify Additional Cases and Exposures. <ol style="list-style-type: none"> a. Exposed asymptomatic residents and HCP (health care professional) should be tested with a series of up to three viral tests. b. Determine approach (contact-tracing, unit-based, facility-based). c. Identify exposures because of close contact. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>d. Test exposures immediately (but not within 24 hours of exposure) and if negative, another test at 48 hours, and if negative another test 48 hours later.</p> <p>5. Returning to Routine Operations</p> <p>a. The facility can return to routine operations when the outbreak has been deemed as complete, which occurs after 14 days without new cases.</p> <p>Evaluation and Monitoring of Residents included:</p> <p>Early detection of signs and symptoms of COVID-19 is key to minimize transmission throughout the facility, as it enables HCP to implement mitigation strategies early.</p> <p>Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms, and it is important to assess for other symptoms such as:</p> <ol style="list-style-type: none"> 1. Fever or chills 2. Cough 3. Shortness of breath 4. Fatigue 5. Muscle or body aches 6. Headache 7. New loss of taste or smell 8. Sore throat 9. Congestion or runny nose 10. Nausea or vomiting 11. Diarrhea <p>With identification of any COVID-19 symptoms, implement prompt isolation and further evaluation for COVID-19 infection.</p> <p>Identify a COVID-19 Care Unit Dedicated to Monitor and Care for Residents with Confirmed COVID-10 included:</p> <p>Dedicating an area within the facility to cohort residents on isolation for confirmed COVID-19 during their infectious period is best practice for decreasing the likelihood of transmission. Components of a COVID-19 Care Unit ideally include the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>1. Physical separation from other rooms and spaces where residents are not confirmed with COVID-19</p> <p>2. Single-person room(s) with designated bathroom(s);</p> <p>a. Place a resident with suspected COVID-19 in a single-person room. The door should be kept closed, if safe to do so. The resident should have a dedicated bathroom.</p> <p>b. If limited single rooms are available, or if numerous residents are simultaneously identified to have symptoms concerning for COVID-19, residents may remain in their current location until cause of symptoms is determined.</p> <p>c. If cohorting, only residents with the same pathogens should be housed in the same room.</p> <p>Resident Cohorting Guide included:</p> <p>1. Resident positive for COVID-19 should not be cohorted with a resident with no respiratory symptoms and not in isolation.</p> <p>2. Resident positive for COVID-19 should only be cohorted with another resident positive for COVID-19.</p> <p>Review of facility policy Guidelines in Managing Respiratory Illness & Outbreaks dated 1/2/24, indicated one case of COVID-19 is considered an outbreak. The facility is to isolate symptomatic residents as appropriate. Only cohort symptomatic residents with same pathogen confirmed via testing. Conduct contact tracing to determine high risk exposures, perform testing and symptom monitoring as required. Conduct daily symptom surveillance until all cases resolved. The facility must follow mandated testing requirements for COVID, test ALL residents with respiratory symptoms and identified high risk exposures for COVID-19 on days 1, 3, and 5.</p> <p>During an interview on 9/11/24, at 12:38 p.m. when asked how she determines how to handle a communicable disease outbreak, Infection Preventionist Employee E1 stated, I go by what the CDC guidelines are, that's pretty much how I handled the situation, whatever the CDC guidelines say. I do reference the PA HAN as well. When asked if roommates of confirmed positive COVID-19 residents were tested , Infection Preventionist Employee E1 stated, The roommate stayed in the room with the positive resident, we treated them as if they were exposed, but all the residents still had the right to come out of their room, we just encouraged masking. I did not perform contact tracing or testing. I think they did before, but the regulations have changed since the beginning of COVID. We only tested residents if they showed symptoms of COVID or if they requested to be tested .</p> <p>During an interview on 9/11/24, at 12:42 p.m. when asked if the facility cohorted COVID-19 positive residents with residents who had not been tested or displaying symptoms, Infection Preventionist Employee E1 stated, No, we did not split the residents, in the past we did. What I observed is that it [COVID-19] would spread when we would move residents room to room.</p> <p>Review of resident clinical records and facility documents revealed:</p> <p>Resident R1 had symptoms of a sore throat and decreased appetite on 8/5/24, and tested positive for COVID-19 on 8/6/24. Resident R1 remained in the same room with Resident R2, who was not tested .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Resident R3 tested positive on 8/7/24, and had symptoms of not feeling well, sweating, and congestion, and remained with roommate Resident R4, who was not tested .</p> <p>Resident R5 tested positive on 8/8/24, and had symptoms of dry cough, and remained with roommate Resident R6, who was not tested .</p> <p>Resident R7 tested positive on 8/10/24, and had symptoms of cough and congestion, and remained with roommate Resident R8, who was not tested .</p> <p>Resident R9 tested positive on 8/13/24, and had symptoms of a fever, sore throat, congestion, and sweating, and remained with roommate Resident R10, who was not tested .</p> <p>Review of a nursing progress note dated 8/13/24, stated, Resident R10 was notified that his roommate has COVID-19. Resident R10 denied having any symptoms. It was explained to Resident R10 that because he has already been exposed to the virus he would need to wash his hands and wear a mask when outside his room. Resident R10 states he understands this but is refusing to re-enter the room. Resident R10 states he hasn't been exposed and spent the night on the dayroom couch.</p> <p>Review of Resident R10's clinical record indicated he was moved to a different room on 8/13/24, upon his request.</p> <p>Resident R11 tested positive on 8/17/24, and had symptoms of congestion and a head cold, and remained with roommate Resident R12, who was not tested .</p> <p>Resident R13 tested positive on 8/17/24, and had no symptoms documented, and remained with roommate Resident R14, who was not tested .</p> <p>Resident R15 tested positive on 8/21/24, and had symptoms of an elevated temperature, and remained with roommate Resident R16, who tested positive on 8/28/24, and had symptoms of a low-grade temperature and feeling flushed.</p> <p>Resident R17 tested positive on 8/24/24, and had symptoms of not feeling well and a low grade temperature, and remained with roommate Resident R18, who was not tested .</p> <p>Resident R19 tested positive on 8/24/24, and had no documented symptoms, and remained with roommate Resident R20, who tested positive on 8/25/24, and had no documented symptoms.</p> <p>Resident R21 tested positive on 8/25/24, and had symptoms of hypoxia (not enough oxygen in the blood). Resident R21 ceased to breathe on 8/26/24. Resident R21 remained with roommate Resident R22, who tested positive on 8/26/24, and had symptoms of hypoxia, altered mental status, and hypoxia.</p> <p>Resident R23 tested positive on 8/27/24, and had flu-like symptoms, and remained with roommate Resident R24, who was not tested .</p> <p>Resident R25 tested positive on 8/27/24, and had symptoms of being flushed, sweaty, emesis, and liquid stools, and remained with roommate Resident R26, who was not tested .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Resident R27 tested positive on 8/28/24, and had symptoms of coughing, congestion, sneezing, and malaise (feeling tired), and remained with roommate Resident R28, who was not tested .</p> <p>Resident R29 tested positive on 8/28/24, and had symptoms of coughing, congestion, sneezing, and malaise, and remained with roommate Resident R10, who was not tested .</p> <p>Resident R30 tested positive on 8/29/24, and had symptoms of wheezing and rhonchi (coarse lung sounds caused by constricted airways), and remained with roommate Resident R31, who was not tested .</p> <p>Resident R32 tested positive on 8/30/24, and had symptoms of a fever, and remained with roommate Resident R33, who tested positive on 8/31/24, and had no documented symptoms.</p> <p>Resident R34 tested positive on 9/1/24, and had symptoms of not feeling well, and a low-grade temperature, and remained with roommate Resident R35, who was not tested .</p> <p>During an interview on 9/11/24, at 3:32 p.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) were made aware that an Immediate Jeopardy (IJ) existed. The NHA was provided the IJ Template and at that time a corrective action plan was requested.</p> <p>On 9/11/24, at 6:11 p.m. an acceptable Corrective Action Plan was received, which included the following interventions:</p> <ul style="list-style-type: none"> - Per PA Department of Health COVID Response Tool Kit, the facility will perform COVID testing for all residents and healthcare providers identified as exposed regardless of vaccination status. - If negative, the facility will test again in 48 hours, after the second negative test (typically day 1, 3, and 5) if additional cases are identified testing should continue on affected units or facility-wide every 3 - 7 days until there are no new cases for 14 days. - The facility is with limited rooms available, residents will remain in their current location until cause of symptoms are determined. - The Medical Director was notified and resident care plans were updated. - All staff will be in-serviced on COVID-19 infection control practices. If any identified COVID infections are noted, the responsible party will be notified. - Education will be completed in person, if staff are not working, phone calls will be made. - To monitor and ongoing compliance, the DON/designee will complete COVID testing. - If COVID positive resident is confirmed, we will shelter in place and pull privacy curtains between both residents, masks will be worn by both residents. - To monitor ongoing compliance, the DON/designee will complete COVID testing according to the PA DOH COVID infection control outbreak response weekly x 4 weeks, then monthly x 2 months. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>- Results of the audits will be forwarded to the facility Quality Assurance Performance Improvement Committee for review upon completion and recommendations.</p> <p>Review of medical records on 9/12/24, indicated that 101 residents that were not previously tested for COVID-19 were tested on [DATE], all with negative results. 84 staff members who had not previously tested positive for COVID-19 were tested , all with negative results.</p> <p>Review of facility documents on 9/12/24 and 9/13/24, revealed that the facility had 105 employees and 100% had received education on the facility's COVID-19 infection control practices. 57 of these employees received formal education on the facility's COVID-19 infection control practices. 48 of these employees had received this education via telephone as they had not been working in the building. Staff are to sign that they received this education when they are in the building before the start of their next shift.</p> <p>During staff interviews conducted on 9/12/24, between 10:15 a.m. and 2:00 p.m. 22 employees confirmed that they received education on the facility's COVID-19 infection control practices. 13 of these employees had received education in person and nine of these employees had received education over the telephone and signed the training sheet prior to the start of their shift.</p> <p>During an interview on 9/12/24, at 10:07 p.m. Nurse Aide Employee E3 stated, I was told we were cited for not doing the right thing. I figured that was coming. They [administration] don't put too much thought and effort into things. We have been telling them they need to do something.</p> <p>The Immediate Jeopardy was lifted on 9/13/24, at 10:54 a.m. when the action plan implementation was verified.</p> <p>During an interview on 9/13/24, at 11:00 a.m. the DON confirmed that the facility failed to maintain an infection prevention and control program by failing to follow infection control guidelines from the Centers for Disease Control (CDC) and the Pennsylvania Department of Health (PA DOH) to reduce the spread of infections and prevent cross-contamination during a COVID-19 outbreak. This failure placed the facility in an Immediate Jeopardy situation for 35 of 47 residents reviewed.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to offering the influenza vaccination for one of five residents (Resident R36).</p> <p>Findings include:</p> <p>Review of facility policy Resident Vaccination Policy dated 1/2/24, indicated influenza, pneumococcal, and COVID vaccination will be administered per provided orders. Consents/refusals/medical ineligibility will be documented in the electronic health record.</p> <p>Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE].</p> <p>Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/25/24, indicated active diagnoses of anemia (too little iron in the body), pneumonia (lung inflammation caused by bacteria or a viral infection), and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior). Section O0250 Influenza Vaccine indicated Resident R36 did not receive the influenza vaccine in the facility during this year's influenza vaccination season, the reason documented as the influenza vaccine was not offered.</p> <p>Review of Resident R36's clinical record failed to include documentation that the influenza vaccination was offered and administered or declined.</p> <p>During an interview on 9/13/24, at 1:08 p.m. Infection Preventionist Employee E1 stated, Resident R36 and his family refused the influenza vaccine. I will have to check his progress notes to find documentation that it was offered and refused.</p> <p>During an interview on 9/13/24, at 1:30 p.m. Infection Preventionist Employee E1 stated, I was unable to find a progress note that the influenza vaccination was offered and refused.</p> <p>During an interview on 9/13/24, at 1:30 p.m. Infection Preventionist Employee E1 confirmed that the facility failed to provide accurate and timely documentation related to offering the influenza vaccination as required.</p> <p>28 Pa. Code 211.5(f) Clinical records</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0885</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Report COVID19 data to residents and families.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility policy, clinical record, and staff interview it was determined that the facility failed to notify families of residents with positive COVID-19 (a contagious disease caused by a virus) test results in a timely manner for two of five COVID-19 positive residents (Residents R3, and R37.)</p> <p>Findings include:</p> <p>Review of the facility policy Guidance in Managing Respiratory Illnesses and Outbreaks dated 1/2/24, indicated that that upon identifying that residents have developed COVID-19, that the facility should notify residents and families.</p> <p>Review of the clinical record revealed that Resident R3 was admitted to the facility on [DATE].</p> <p>Review of Resident R3 Minimum Data Set (MDS - periodic assessment of resident's care needs) dated 6/19/24, revealed diagnoses of high blood pressure, dysphagia (difficulty swallowing), and iron deficiency anemia (when blood does not have enough healthy red blood cells to carry oxygen throughout the body as a result of not enough iron).</p> <p>Review of Resident R3's clinical record revealed a nursing progress note dated 8/7/24, that indicated that Resident R3 was tested for COVID-19 after complaining of not feeling well, and that she tested positive for COVID-19.</p> <p>Review of Resident R3's progress notes failed to include documentation that Resident R3's representative was notified of COVID-19 status.</p> <p>Review of the clinical record revealed that Resident 37 was admitted to the facility on [DATE].</p> <p>Review of Resident 37's MDS dated [DATE], indicated diagnoses of high blood pressure, dysphagia (difficulty swallowing), and chronic pain syndrome.</p> <p>Review of COVID-19 Surveillance Form indicated that Resident R37 complained of flu-like symptoms on 8/26/24, and that she tested positive for COVID-19.</p> <p>Review of Resident R37's progress notes failed to include documentation that Resident R37's representative was notified of COVID-19 status.</p> <p>During an interview on 9/13/24, at 10:15a.m. Director of Nursing Confirmed that the facility failed to notify the families for two of five residents (Resident R3, and R37) with positive COVID-19 results as required.</p> <p>28 Pa Code: 201.29 (a) Resident Rights.</p> <p>28 Pa Code: 201.14 (a) Responsibility of Licensee</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 201.18 (e)(1)(2)(3) Management.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/16/2024
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive 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 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination for one of five residents (Resident R36).</p> <p>Findings include:</p> <p>Review of facility policy Resident Vaccination Policy dated 1/2/24, indicated influenza, pneumococcal, and COVID vaccination will be administered per provided orders. Consents/refusals/medical ineligibility will be documented in the electronic health record.</p> <p>Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE].</p> <p>Review of Resident R36's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/25/24, indicated active diagnoses of anemia (too little iron in the body), pneumonia (lung inflammation caused by bacteria or a viral infection), and schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior).</p> <p>Review of Resident R36's clinical record indicated the resident last received a COVID-19 vaccination on 11/2/22.</p> <p>Review of Resident R36's clinical record failed to include documentation that the COVID-19 vaccination was offered and administered or declined since 11/2/22.</p> <p>During an interview on 9/13/24, at 1:08 p.m. Infection Preventionist Employee E1 stated, Resident R36 and his family refused the COVID-19 vaccine. I will have to check his progress notes to find documentation that it was offered and refused.</p> <p>During an interview on 9/13/24, at 1:30 p.m. Infection Preventionist Employee E1 stated, I was unable to find a progress note that the COVID-19 vaccination was offered and refused.</p> <p>During an interview on 9/13/24, at 1:30 p.m. Infection Preventionist Employee E1 confirmed that the facility failed to provide accurate and timely documentation related to offering the COVID-19 vaccination as required.</p> <p>28 Pa. Code 211.5(f) Clinical records</p>		