STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395986	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kittanning Health & Rehab Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, controlled medication shift reconciliation records and staff interviews, it was determined that the facility failed to implement procedures to promote accurate accounting of controlled medications on two of two medication carts reviewed (Unit One Medication Cart and Unti 2B Medication Cart) and failed to ensure accurate administration of medications, resulting in a medication error for one of five residents (Resident R1).Findings include:Review of facility policy Inventory Control of Controlled Substances dated 1/12/25, indicated facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on a Controlled Substance Count Verification/Shift Count Sheet. Review of facility policy General Dose Preparation and Medication Administration dated 1/12/25, indicated prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following:Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.Confirm that the MAR (Medication Administration Record) reflects the most recent medication orderDocument the administration of controlled substances in accordance with applicable law.Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application site) on appropriate forms.During a review of the Shift Verification of Controlled Substances Count log for the Unit One Medication Cart Rooms 101-121 on 11/18/25, at 11:29 a.m. revealed the oncoming nurse and/or outgoing nurse failed to sign the sheet during shift change to verify counts of controlled drugs on the following dates:10/17/25, 7 a.m. - 3 p.m. shift10/23/25, 3 p.m. - 11 p.m. shift10/23/25, 11 p.m. - 7 a.m. shift11/12/25, 7 a.m. - 3 p.m. shift11/12/25, 3 p.m. - 11 p.m. shift11/12/25, 11 p.m. - 7 a.m. shift During a review of the Shift Verification of Controlled Substances Count log for the Unit One Medication Cart Rooms 122-133 on 11/18/25, at 11:33 a.m. revealed the oncoming nurse and/or outgoing nurse failed to sign the sheet during shift change to verify counts of controlled drugs on the following dates:10/23/25, 7 p.m. - 7 a.m. shift11/2/25, 3 p.m. - 11 p.m. shift11/2/25, 11 p.m. - 7 a.m. shift During an interview on 11/18/25, at 11:38 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the above observations and stated, Count should be done every shift. It's mostly the agency staff who don't do it, I try to remind them. During a review of the Shift Verification of Controlled Substances Count log for the Unit 2B Medication Cart on 11/18/25, at 11:48 a.m. revealed the oncoming nurse and/or outgoing nurse failed to sign the sheet during shift change to verify counts of controlled drugs on the following dates:10/2/25, 11 p.m. - 7 a.m. shift10/11/25, 11 p.m. - 7 a.m. shift10/13/25, 11 p.m. - 7 a.m. shift10/14/25, 7 a.m. - 3 p.m. shift10/18/25, 11 p.m. - 7 a.m. shift10/28/25, 7 a.m. - 3 p.m. shift11/7/25, 11 p.m. - 7 a.m. shift11/10/25, 11 p.m. - 7 a.m. shift11/15/25, 11 p.m. - 7 a.m. shift11/17/25, 11 p.m. - 7 a.m. shift During an interview on 11/18/25, at 11:54 a.m. LPN Employee E2 confirmed the above observations and stated, It's mostly night shift that forgets to sign. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/4/25, indicated diagnoses of anxiety, depression, and history of falling. Review of a physician order dated 1/21/25, indicated to administer lorazepam (a schedule IV medication given to treat anxiety) 0.5 milligrams by mouth three times a day. Review of a progress note dated 9/22/25, stated, At 1420 (2:20 p.m.) LPN notified this nurse that resident's lorazepam was signed out at 0700 (7 a.m.), then given again at 1000 (10 a.m.). This nurse notified RN (Registered Nurse) Supervisor of medication error. Physician notified, resident representative notified. Resident does not appear to have any side/adverse effects. Review of a progress note dated 9/22/25, stated, Potential medication error due to no report from midnight shift nurse giving unscheduled medication. No report of PRN given either. Also no documentation of medication in electronic medical record. RN Sup (Supervisor) made aware, incident report completed. Review of a witness statement dated 9/23/25, completed by LPN Employee E6 stated, At 1430 (2:30 p.m.) LPN Employee E3 brought the red narcotic book from Unit 2A to this nurse stating that the night shift nurse gave the resident her AM (morning) Ativan (lorazepam) and signed it out at 0700. LPN Employee E3 proceeded to tell this nurse that she also gave Resident R1 her AM Ativan at 1000. LPN Employee E3 stated that she did not notice until the end of the shift because she doesn't sign her narcotics out until her shift is over. Review of a witness

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for two of three residents reviewed (Residents R1 and R2).Findings include: Review of facility policy General Dose Preparation and Medication Administration dated 1/12/25, indicated prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including but not limited to the following:Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident.Confirm that the MAR (Medication Administration Record) reflects the most recent medication orderDocument the administration of controlled substances in accordance with applicable law.Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application site) on appropriate forms. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/4/25, indicated diagnoses of anxiety, depression, and history of falling. Review of a physician order dated 1/21/25, indicated to administer lorazepam (a schedule IV medication given to treat anxiety) 0.5 milligrams (mg) by mouth three times a day. Review of a progress note dated 9/22/25, stated, At 1420 (2:20 p.m.) Licensed Practical Nurse (LPN) notified this nurse that resident's lorazepam was signed out at 0700 (7 a.m.), then given again at 1000 (10 a.m.). This nurse notified RN (Registered Nurse) Supervisor of medication error. Physician notified, resident representative notified. Resident does not appear to have any side/adverse effects. Review of a progress note dated 9/22/25, stated, Potential medication error due to no report from midnight shift nurse giving unscheduled medication. No report of PRN given either. Also no documentation of medication in electronic medical record. RN Sup (Supervisor) made aware, incident report completed. Review of a witness statement dated 9/23/25, completed by LPN Employee E6 stated, At 1430 (2:30 p.m.) LPN Employee E3 brought the red narcotic book from Unit 2A to this nurse stating that the night shift nurse gave the resident her AM (morning) Ativan (lorazepam) and signed it out at 0700. LPN Employee E3 proceeded to tell this nurse that she also gave Resident R1 her AM Ativan at 1000. LPN Employee E3 stated that she did not notice until the end of the shift because she doesn't sign her narcotics out until her shift is over. Review of a witness statement dated 9/23/25, completed by LPN Employee E3 stated, During count at 0715-0730 (7:15 a.m. - 7:30 a.m.) with LPN Employee E4, there was a medication card that was counted only #23 Ativans. When LPN Employee E4 said #23, nurse stated No there are #22. LPN Employee E4 then signed her name in the narc book and signed out the medication. Nurse (I) assumed she had given the medication and just forgot to sign it out making the count add up. During report LPN Employee E4 stated that the residents were good. There was no COVID resident. She also stated it was a crazy night and she is never coming back to this facility. Then she left. Review of a witness statement dated 9/25/25, completed by LPN Employee E4 stated, 0600 (6 a.m.) giving morning meds and signed out Ativan for 0700 (7 a.m.) was due at 0800 (8 a.m.). Unsure if I gave it or what happened to it.Review of Resident R1's Individual Narcotic Log sheet for Ativan 0.5 mg revealed the medication was signed out as administered on 9/22/25, at 0700 by LPN Employee E4 and signed out as administered on 9/22/25, at 1000 by LPN Employee E3.Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of depression, anxiety, and chronic pain.Review of a physician order dated 4/4/25, indicated to administer chlordiazepoxide (Librium - a schedule IV medication given to treat anxiety) 10 mg by mouth once a day in the morning. Review of a physician order dated 4/5/25, indicated to administer chlordiazepoxide 5 mg by mouth once a day at bedtime.Review of a progress note dated 10/2/25, stated, This writer alerted to questionable med error on 9/29 and 9/30. After review it is noted that original orders are Librium 10 mg q (every) day and Librium 5 mg q hs (night). Resident has been given Librium 10 mg at hs on the 29/30 of September. CRNP (Certified Registered Nurse Practitioner) and resident representative have been notified of incident. Resident has had no adverse reactions to the error. During an interview on 11/18/25, at 2:17 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure that residents are free of significant medication errors for two of three residents reviewed (Residents R1 and R2). 28 Pa. Code: 201. 14(a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1) Management 28 Pa. Code: 211.10 (c) Resident