

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  01/16/2025
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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain call bells were in reach for one of six residents as required (Resident R4).</p> <p>Findings include:</p> <p>The facility policy Call Lights dated 2/24/23, last reviewed 1/2/24, indicated it is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room. The facility responds to residents needs and requests.</p> <p>Review of Resident R4's clinical record indicated admission to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/28/24, indicated diagnoses of hypertension (high blood pressure) polyneuropathy (disease that affects many nerves in the body) and depression.</p> <p>Review of Resident R4's care plan dated 1/17/24, indicated the resident was at risk for falling due to poor safety awareness. It was indicated to keep the call light in reach at all times.</p> <p>During an interview and observation on 1/12/25, at 9:40 a.m. Resident R4 was sitting in her wheelchair in her room. The resident was observed slouched down in her wheelchair, yelling My back. Resident was in obvious distress, crying out.</p> <p>Interview on 1/12/25 at 9:47 a.m. Nurse Aide, Employee E11 confirmed the call bell was not in reach of Resident R4.</p> <p>Interview on 1/12/25, at 1:50 p.m. the Nursing Home Administrator confirmed facility failed to make certain call bells were in reach for one of six residents as required. (Resident R4).</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p> <p>28 Pa Code: 201.29 (l)(o) Resident rights.</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>46167</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for one of two residents (Resident R87).</p> <p>Findings include:</p> <p>A review of the facility Resident Rights Regarding Treatment and Advance Directives dated 1/12/25, and previously dated 1/2/24, indicated that Advance Directives will be discussed with resident or their representative to determine if any Advance Directives have been chosen or of the resident has any questions.</p> <p>Review of Resident R87's admission record indicated the resident was admitted to the facility 11/15/24.</p> <p>A review of Resident R87's Minimum Data Set (MDS - periodic assessment of care needs) dated 11/21/24, included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and morbid obesity due to excess calories.</p> <p>A review of the clinical record failed to reveal an Advanced Directive or documentation that Resident R87 was given the opportunity to formulate an Advanced Directive.</p> <p>During an interview on 1/15/25, at 12:23 p.m. Social Services Director Employee E6 confirmed that the clinical record did not include documentation that Resident R87 was afforded the opportunity to formulate Advanced Directives.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>35785</p> <p>Based on facility policy review, observations, and resident and staff interviews, it was determined that the facility failed to maintain a safe, clean, and home-like environment for one of three sampled residents (Resident R47).</p> <p>Findings include:</p> <p>During observations on 1/14/25, at 9:54 a.m. Resident R47's bed was found with red substance on his sheets and red substance on the floor next to his bed.</p> <p>During an interview on 1/14/25, at 9:55 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed that the facility failed to maintain a safe, clean, and home-like environment for Resident R47 as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, clinical record review, reports submitted to the State, and staff interview, it was determined that the facility failed to report an allegation of abuse in the required timeframe one of four residents (Resident R80).</p> <p>Findings include:</p> <p>Review of facility policy Review of facility policy Abuse, Neglect, and Exploitation dated 1/2/24, last reviewed 1/12/25, indicated all allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing, and to the applicable State Agency. All serious incidents involving a resident will be reported to the Department of Health (State Agency) field office within 24 hours.</p> <p>Review of the clinical record indicated Resident R80 was admitted to the facility on [DATE].</p> <p>Review of Resident R80's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/22/24, indicated diagnoses of anemia (too little iron in the blood), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interest).</p> <p>Review of a progress note dated 12/31/24, at 3:46 a.m. stated, According to Nurse Aide on unit, Resident R80 was walking in the hallway with Resident R66 when Resident R66 hit Resident R80's face with her hand and her left side with a cane. Staff separated the two and Resident R80 didn't say what precipitated the violence but expressed fear of it happening again. No obvious signs of trauma on Resident R80. MD (physician) and Social Services notified and family to be notified on 7 a.m. - 3 p.m. shift.</p> <p>Review of incidents submitted to the State Agency on 1/16/25, at 8:50 a.m. did not include the resident-to-resident abuse allegation on 12/31/24.</p> <p>During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator (NHA) stated that the Director of Nursing confirmed that he did not report the resident-to-resident abuse allegation that occurred on 12/31/24.</p> <p>During an interview on 1/16/25, at 5:46 p.m. the NHA confirmed that the facility failed to report an allegation of abuse in the required timeframe one of four residents (Resident R80).</p> <p>28 Pa. Code 201.14(a)(c).(e.) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.</p> <p>28 Pa. Code 201.20(b) Staff development.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.10(c).(d) Resident care policies.</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of three residents with facility-initiated transfers (Resident R21, R30, and R78).</p> <p>The findings include:</p> <p>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].</p> <p>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body).</p> <p>Review of Resident 21's clinical record revealed that the resident was transferred to the hospital on 10/19/24.</p> <p>Review of Resident R21's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE].</p> <p>Review of Resident R30's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of the brain.</p> <p>Review of Resident R30's clinical record revealed that the resident was transferred to the hospital on 2/21/24.</p> <p>Review of Resident R30's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE].</p> <p>Review of Resident R78's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease, dementia, and malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R78's clinical record revealed that the resident was transferred to the hospital on 12/1/24.</p> <p>Review of Resident R78's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>During an interview on 1/15/25, at 1:05 p.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer for three out of three residents sampled with facility-initiated transfers (Residents R21, R30, and R78).</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization ) for three of three resident hospital transfers or therapeutic leave of absence (Resident R21, R30 and R78).</p> <p>Findings Include:</p> <p>Review of the facility policy Bed Hold Notice dated 1/12/25, and previously dated 1/2/24, indicated that the bed hold policy will be provided to residents at the time of transfer. In the case of an emergency, the paperwork should be provided within 24 hours.</p> <p>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].</p> <p>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body).</p> <p>Review of Resident 21's clinical record revealed that the resident was transferred to the hospital on 10/19/24, and returned to the facility on [DATE].</p> <p>Review of Resident R21's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/19/24.</p> <p>Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE].</p> <p>Review of Resident R30's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of the brain.</p> <p>Review of Resident R30's clinical record revealed that the resident was transferred to the hospital on 2/21/24, and returned to the facility on [DATE].</p> <p>Review of Resident R30's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/21/24.</p> <p>Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE].</p> <p>Review of Resident R78's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease, dementia, and malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident R78's clinical record revealed that the resident was transferred to the hospital on 12/1/24, and returned to the facility on [DATE].</p> <p>Review of Resident R78's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/1/24.</p> <p>During an interview on 1/15/25, at 1:05 p.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R21, R30, and R78.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on a review of Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that MDS assessments accurately reflected the resident's status for one of three residents (Resident R30).</p> <p>Findings include:</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:</p> <p>- O0110K1, Hospice care: code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions.</p> <p>Review of the clinical record indicated Resident R30 was admitted to the facility on [DATE].</p> <p>Review of Resident R30's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and senile degeneration of the brain.</p> <p>Review of a physician order dated 3/23/24, indicated to admit Resident R30 to hospice services, effective 3/23/24.</p> <p>Review of Resident R30's Significant Change MDS dated [DATE], revealed that Section O0110K1 (Hospice care) was coded no, indicating that the resident did not receive any hospice care during the 14-day assessment period.</p> <p>During an interview on 1/15/25, at 3:00 p.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that the facility failed to make certain that resident assessments were accurate as required.</p> <p>28 Pa. Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of four residents (Resident R4).</p> <p>Findings include:</p> <p>Review of facility policy Comprehensive Care Planning dated 1/2/24 indicated the resident care conference meets as scheduled to discuss each resident, review the previous care plan and to finalize the development of the current care plan. Adjustments are made by the interdisciplinary team to ensure that all programs and identified category of needs are addressed and that the plan is oriented toward preventing a decline in functioning.</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of a progress note dated 4/21/24, stated, Resident (Resident R4) has been exit seeking all shift. Constantly at desk and asking staff how to get out. This writer explained to resident that he cannot leave. Resident walked away from this writer and went down the hall saying F**k you then. Educated Resident that his language was not appropriate and Resident stated too bad. Approached desk again and stated to this writer that he needed to leave because I just came to visit. Educated again that Resident cannot leave the unit. Resident stated I need to get the f**k out of here. Educated Resident again that his language was not appropriate. Resident walked away from the desk.</p> <p>Review of a progress note dated 7/31/24, stated, The D.O.N. (Director of Nursing) was advised by the L.P.N. (Licensed Practical Nurse) on the MIU (Memory Impaired Unit) that the resident (Resident R4) was requesting sexual favors from a female resident. The resident requested fell atio and will be monitored by staff to ensure the safety of other residents who dwell on the MIU. It will be reported to the direct care staff shift to shift of this incident, so all staff have knowledge to monitor this resident's inappropriate behavior.</p> <p>Review of a progress note dated /12/24, stated, I observed a female resident wheeling her w/c (wheelchair) into this residents (Resident R4) room and when I went to get her the male resident had his hand in his pants. I asked him what he was doing with his hand and he showed me his other hand. I asked him what he had in his other hand and he said his dick, which I knew because he was masturbating with it. I removed the female resident to the dining room and closed his curtain for privacy.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a progress note dated 12/4/24, stated, Resident (Resident R4) was being extremely disruptive during the afternoon bingo activity. Staff stated he was upset he ate all of his popcorn quickly and wanted the other residents. When staff said no he said F*** you, suck my dick and was calling her a B****, which upset the group playing bingo at the time.</p> <p>Review of a progress note dated 1/2/25, stated, Resident (Resident R4) was verbally threatening and raising his fists as if to hit another male resident that wandered in to his room. He was not easily redirected. He is also verbally abusive towards staff calling us obscene names. I was able to get the other male resident away from him without incident.</p> <p>Review of a progress note dated 1/2/25, stated, Resident (Resident R4) tried to push a female resident to the floor this afternoon. She had got too close to him and pulled on his pant leg. I told him he cannot be pushing other residents and he told me to suck his dick and called me a f***ing whore and a F***ing C***. I asked him to please not call staff names and being disrespectful and he continued. I just kept the other resident safe and walked away from him.</p> <p>Review of Resident R4's care plan dated 1/12/25, indicated Resident has verbal and physical behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others, pushing and combativeness).</p> <p>Review of Resident R4's care plan on 1/13/25, failed to include goals and interventions regarding the resident's verbal and physical behavioral symptoms prior to the care plan developed on 1/12/25.</p> <p>During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure a resident's care plan was updated and revised to reflect the resident's specific care needs as required.</p> <p>28 Pa. Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.11(a) Resident care plan.</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  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Kittanning Care Drive Kittanning, PA 16201	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46167</p> <p>Provide activities to meet all resident's needs.</p> <p>Based on a review of facility policy and documents, resident interviews, and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for four of five weeks (12/10/24 through 12/21/24, and 12/26/24 through 1/16/25).</p> <p>Findings include:</p> <p>Review of facility policy Activities dated 1/12/25, and previously dated 1/2/24, indicated the facility is to provide an ongoing resident-centered Life Enrichment Program, based on comprehensive assessments and care plans will be provided. The program will be designed to meet the interests (including hobbies and cultural preferences) and the abilities of each resident including as their physical; mental; emotional; social; spiritual; psychosocial and leisure needs. The program will create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (security, autonomy, growth, connectedness, identity, joy, and meaning). The choices, previous positive lifestyles, and daily schedules of each resident will be incorporated. Programs, equipment, and materials will be adapted as necessary.</p> <p>Review of document COVID-19 (an infectious respiratory disease) Infection Control and Outbreak Response Toolkit for Long-Term-Care, dated February 2024, stated to arrange seating in common areas, treatment areas, and during group activities so that residents are at least six feet apart. Consider scheduling appointments to limit the number of residents in common areas or participating in group activities at one time.</p> <p>During an interview on 1/12/25, at 11:02 a.m. Resident R52 stated We don't have any activities right now. Everyone is closed up in their rooms.</p> <p>During an interview on 1/12/25, at 11:08 a.m. Resident R5 stated that there are no group activities at this time due to COVID, and added It's boring.</p> <p>During an interview on 1/15/25, at 10:54 a.m. Infection Preventionist (IP) Employee E1 stated that the facility had a COVID outbreak that began on 11/29/24, and that it had not been lifted.</p> <p>During an interview on 1/16/25, at 10:46 a.m. Activities Director (AD) Employee E7 confirmed that all group activities have been cancelled. I was told to suspend them with COVID. They closed the Dining Room which limits some activities. AD Employee E7 stated that she was told by the Director of Nursing (DON), and IP Employee E1 to stop group activities on 12/10/25, and to resume them on 12/21/24, and to stop them again on 12/26/24. Group activities currently remain suspended. AD Employee E7 stated that she did not modify any group activities with social distancing or by limiting any group size during this time frame. AD Employee E7 confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for four of five weeks.</p> <p>28 Pa. Code: 201. 18(b)(3) Management.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code: 207.2(a) Administrators Responsibility.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</b></p> <p>Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to monitor and ensure proper treatment of resident wounds and complete weekly skin assessments for two of four (Resident R4, and Resident R199).</p> <p>Findings include:</p> <p>Review of facility policy Skin and Wound Care Best Practices dated 1/2/24, and last reviewed 1/12/25, indicated the licensed nurses will complete a Weekly Skin Check. This review is in addition to the nursing assistant's shower sheet skin reviews.</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of a progress note dated 4/11/24, indicated Resident R4 was admitted to the facility with a chronic abdominal wound measuring 9 cm (centimeters) x 5 cm.</p> <p>Review of Resident R4's clinical record failed to reveal documentation of the resident's abdominal wound for the week of 9/1/24.</p> <p>Review of Resident R4's clinical record revealed the resident's abdominal wound received a status of healed on 9/19/24.</p> <p>Review of a progress note dated 9/24/24, stated, Resident seen at request of nurse due to concern for abdominal wound opening back up. Resident alert and agreeable to treatment. The two areas that were healed have now opened back up. Each area measures approximately 2 cm x 2 cm. Pink and moist. Cleaned and dressed with Promogran (a type of dressing that maintains a moist environment and promotes healing) per wound care centers last order. Covered with a dry dressing.</p> <p>Review of Resident R4's clinical record failed to reveal documentation of the resident's abdominal wound for the weeks of 12/22/24, and 12/29/24.</p> <p>During an interview on 1/16/25, at 5:46 p.m. the Nursing Home Administrator confirmed that the facility failed to monitor resident wounds and complete weekly skin assessments as required.</p> <p>Review of Resident R199's admission record indicated the resident was admitted to the facility 11/15/24.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident R199's MDS dated [DATE], included diagnoses of high blood pressure, infection due to cardiac, and vascular device implants, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister). Section M210 stated that Resident R199 had an unhealed pressure injury, and section M1040 stated that he also had a surgical wound.</p> <p>Review of Resident R199's physician order dated 1/8/25, to clean wound bed with wound cleaner, pat dry, apply thin piece of MediHoney alginate (a topical antimicrobial medication for wounds) to wound bed cover with foam dressing.</p> <p>Review of the above order does not indicate what area of the body, or what wound to apply this medication.</p> <p>Review of Resident R199's physician order dated 12/25/24, for Wound VAC (vacuum assisted closure- a device that uses suction to help wounds heal) dressing three times per week.</p> <p>Review of the above order does not indicate what area of the body, or what wound to apply this treatment.</p> <p>During an interview on 1/15/25 at 4:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that Resident R199 has two different wounds, but that the facility failed to indicate which treatment should be applied to the surgical wound to ensure proper treatment.</p> <p>28 Pa. Code 201.18 (b)(1) Management</p> <p>28 Pa. Code 201.29(d) Resident Rights</p> <p>28 Pa. Code 211.10 (c)(d) Resident Care policies</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35785</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to make certain that residents received proper treatment and monitoring for pressure ulcers for two of three sampled residents (Residents R1 and R199).</p> <p>The facility Pressure injury prevention and treatment policy dated 1/2/24, and last reviewed 1/12/25, indicated that residents will be assessed for pressure injury risk on admission. Monitoring will be at least weekly, and an evaluation of the pressure ulcer/pressure injury will be documented. All assessments will include location/stage, size, pain, wound bed and appearance.</p> <p>Review of Resident R1's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R1's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/7/24, indicated that she had diagnoses that included Peripheral vascular disease (PVD-a progressive narrowing of the blood vessels impacting blood flow to the limbs), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), pressure ulcers (an injury to the skin and underlying tissue, primarily caused by prolonged pressure on the skin), and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). The diagnoses were current upon review. The MDS Section M0300B-Unhealed pressure ulcer injury section indicated the number of pressure areas as a 1.</p> <p>Review of Resident R1's care plans dated 10/3/24, indicated to assess the pressure ulcer for stage, size (length, width, and depth), and condition of surrounding skin weekly.</p> <p>Review of Resident R1's physician orders dated 12/24/24, indicated to cleanse left buttock wound.</p> <p>Review of Resident R1's wound assessment dated [DATE], indicated that the wound measured 3.0 cm x 2.8 cm x 0.2 cm.</p> <p>Review of Resident R1's wound assessments, nurse progress notes and physician notes did not include wound assessments for the weeks of 12/25/24 and 1/1/25.</p> <p>During an interview on 1/14/25, at 9:35 a.m. Registered Nurse Employee E3 confirmed that the facility failed to make certain that Resident R1 was monitored and assessed for her pressure ulcers/wounds as required.</p> <p>Review of Resident R199's admission record indicated the resident was admitted to the facility 11/15/24.</p> <p>A review of Resident R199's MDS dated [DATE], included diagnoses of high blood pressure, infection due to cardiac, and vascular device implants, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister). Section M210 stated that Resident R199 had an unhealed pressure injury, and section M1040 stated that he also had a surgical wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R199's physician order dated 1/8/25, to clean wound bed with wound cleaner, pat dry, apply thin piece of MediHoney alginate (a topical antimicrobial medication for wounds) to wound bed cover with foam dressing.</p> <p>Review of the above order does not indicate what area of the body, or what wound to apply this medication.</p> <p>Review of Resident R199's physician order dated 12/25/24, for Wound VAC (vacuum assisted closure- a device that uses suction to help wounds heal) dressing three times per week.</p> <p>Review of the above order does not indicate what area of the body, or what wound to apply this treatment.</p> <p>During an interview on 1/15/25 at 4:00 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that Resident R199 has two different wounds, but that the facility failed to indicate which treatment should be applied to the pressure ulcer to ensure proper treatment.</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on review of facility policy, review of facility documentation, resident interview, review of clinical records and staff interview, it was determined that the facility failed to assess residents for smoking safety for one of two residents (Resident R52).</p> <p>Findings include:</p> <p>Review of the facility policy Resident Smoking dated 1/12/25, and previously dated 1/2/24, indicated that during the admission process, nursing will ask residents if they smoke or have a desire/intent to smoke while in the facility. Anyone answering yes is further assessed for smoking safety awareness and the need for reasonable physical or safety accommodations. The assessment is completed thereafter on readmission, quarterly, and with any significant change in the resident's condition.</p> <p>Review of the facility Smoking List, provided on 1/12/25, indicated that Resident R52 was a current smoker.</p> <p>Review of clinical record revealed that Resident R52 was originally admitted to the facility on [DATE].</p> <p>Review of Resident R52's clinical record indicated that a Smoking Risk form was completed on 10/8/24, that stated that Resident R52 does not smoke and intends to remain non-smoking.</p> <p>Review of Resident R52's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/9/25, indicated diagnoses of low potassium in the blood, depression, and nicotine dependence. Section J1300 stated yes to current tobacco use.</p> <p>During an interview on 1/14/25 at 10:32 a.m. Resident R52 confirmed that she is a smoker and stated that she goes out to smoke three times a day.</p> <p>During an interview on 1/15/25 at 3:06 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that Resident R52 is a smoker, and that the facility failed to properly assess Resident R52's smoking risk on 10/8/24.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.11(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of resident clinical records, facility policy and staff interview, it was determined the facility failed ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one resident receiving hemodialysis (Resident R45).</p> <p>Findings include:</p> <p>A review of the facility Hemodialysis Care Policy dated 8/24/23, reviewed 1/12/25, indicated medications will be administered as ordered by the provider.</p> <p>A review of the facility Resident Change in Condition Policy dated 6/27/24, indicated the licensed nurse will recognize and intervene in the event of a change in resident condition. The physician will be notified as soon as the nurse identified the change in condition and the resident is stable. The physician must be notified when there is a significant change in the resident's physician condition.</p> <p>A review of Resident R45's clinical record indicated the resident was admitted on [DATE], and readmitted on [DATE].</p> <p>A review of Resident R45's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/15/24, with the diagnosis of hypertension (high blood pressure) end stage renal disease (last stage of kidney failure) and diabetes (high sugar in the blood).</p> <p>A review of Resident R45's care plan dated 7/17/23, indicated the resident requires Dialysis (a medical procedure that removes waste products of metabolism from the bloodstream when the kidneys are unable to perform that function) and is at risk for fluid volume deficit. Interventions included to follow up with Dialysis book, chart, and record information as noted. Monitor for signs and symptoms of hypovolemia (not enough fluid in body) or hypervolemia (too much fluid in the body). It was indicated the resident will maintain fluid balance as evidenced by state/appropriate weight and vital signs.</p> <p>A review of Resident R45's physician orders dated 12/5/23, indicate dialysis Monday, Wednesday, and Friday.</p> <p>Review of Resident R45's clinical record revealed the following:</p> <ul style="list-style-type: none"> <li>-1/3/24, at 7:45 a.m. 267.3 lbs. entered by Registered Dietary technician, Employee E12</li> <li>-1/6/24, at 7:44 a.m. 268.8 lbs. entered by Registered Dietary technician, Employee E12</li> <li>-1/8/25, at 7:43 a.m. 267.9 lbs. entered by Registered Dietary technician, Employee E12</li> <li>-1/8/25, at 10:21 a.m. 285 lbs. (17.1 lb. weight gain) entered by LPN, Employee E13</li> </ul> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-1/10/25, at 9:02 a.m. 285 lbs. entered by LPN, Employee E13</p> <p>-1/13/25, at 9:08 a.m. 285 lbs. entered by LPN, Employee E13</p> <p>A review of Resident R45's progress note dated 1/10/25, entered by Registered Dietary technician, Employee E12 indicated the post dialysis weights obtained from dialysis center from 1/3/25, 1/6/25, and 1/8/25, were entered accordingly.</p> <p>A review of Resident R45's clinical record from 1/8/25, through 1/13/25, failed to include evidence a doctor was notified of Resident R45's 17.1 pound weight gain.</p> <p>During an interview on 1/13/25, at 12:22 p.m. LPN, Employee E13 stated if a resident has a weight gain of greater than five pounds then a doctor must be notified. It was indicated the dietician tracks weight gain and if there is a discrepancy the resident must be reweighed. It was indicated the Registered Nurse is responsible for notifying the physician. LPN, Employee E13 stated the dietician should notify the RN, then the RN contacts the doctor. LPN, Employee E13 confirmed Resident R45's physician was not made aware of Resident R45's change in condition.</p> <p>A review of Resident R45's Dialysis communication binder revealed a physician order dated 1/12/25, to administer cinacalcet 120mg on non-dialysis days.</p> <p>A review of Resident R45's physician orders dated 1/13/25, indicated to administer 30 mg cinacalcet with 90 mg cinacalcet on Monday, Wednesday, and Friday after dialysis. The facility failed to enter Resident R45's order for the correct days.</p> <p>During an interview on 1/14/25, at 10:58 a.m. the Director of Nursing confirmed the facility failed to enter Resident R45's medication order from dialysis correctly. The DON confirmed the failed ensure residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one of one resident receiving hemodialysis (Resident R45).</p> <p>28 Pa. Code: S211.5(g)(h) Clinical records.</p> <p>28 Pa. Code: S201.14(a)(b)(e)(1)(3) Management.</p> <p>28 Pa. Code: S211.10(c) Resident care policies.</p> <p>28 Pa. Code: S211.12(c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least every 60 days after the first 90 days of admission for one of nine residents reviewed (Residents R86) and failed to ensure a physician completed the initial visit for one of nine residents (Resident R201).</p> <p>Findings include:</p> <p>Review of Resident R86's clinical record indicated admission to the facility on [DATE].</p> <p>Review of Resident R86's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/13/24, indicated diagnoses of stroke (occurs when the supply of blood to the brain is reduced or blocked completely, which prevents brain tissue from getting oxygen and nutrients.) hypertension (high blood pressure) and dysphagia (difficulty swallowing).</p> <p>Review of Resident 86's clinical record revealed there was no documented evidence that Resident R86 was seen by a physician or physician delegate for 232 days between 2/7/24, and 9/25/24.</p> <p>Review of Resident R201's clinical record indicated admission to the facility on [DATE].</p> <p>Review of Resident R201's Minimum Data Set (MDS - a periodic assessment of care needs) dated 12/24/24, indicated diagnoses of anxiety, depression, and bipolar disorder (a chronic mood disorder that causes intense shifts in mood, energy levels and behavior).</p> <p>Review of Resident R201's clinical record revealed a new patient visit was completed by Certified Registered Nurse Practitioner, Employee E14 on 12/17/24. The facility failed to ensure the resident's initial visit was conducted by a physician.</p> <p>During an interview on 1/16/25, at 5:36 p.m. the Nursing Home Administrator confirmed the facility failed to ensure that physician visits were conducted at least every 60 days after the first 90 days of admission for one of nine residents reviewed (Residents R86) and failed to ensure a physician completed the initial visit for one of nine residents (Resident R201).</p> <p>28 Pa. Code 211.2(a) Physician Services.</p>		

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NAME OF PROVIDER OR SUPPLIER  Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Kittanning Care Drive Kittanning, PA 16201	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of facility policy, controlled drug shift count record, and staff interview, it was determined that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs for one of three closed record residents reviewed (Closed Record (CR) Resident R96).</p> <p>Findings include:</p> <p>Review of facility policy Disposal/Destruction of Expired or Discontinued Medication dated [DATE], last reviewed [DATE], indicated destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional. Discontinued and unused medications of discharged or deceased residents shall be immediately removed from the medication cart and brought to nursing supervisory staff.</p> <p>Review of the clinical record indicated CR Resident R96 was admitted to the facility on [DATE].</p> <p>Review of CR Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression (a constant feeling of sadness and loss of interest).</p> <p>Review of a physician order dated [DATE], indicated to administer morphine solution 5 mg (milligrams) every four hours as needed for shortness of breath.</p> <p>Review of a progress note dated [DATE], stated, CR Resident R96 CTB (ceased to breathe) at 10:36 a.m. Certified Registered Nurse Practitioner pronounced. Resident Representative notified and is to return call with funeral arrangements.</p> <p>Review of the Controlled Medication Utilization Record for CR Resident R96's morphine revealed the documented Date of Disposition was [DATE], three days after CR Resident R96 had ceased to breathe in the facility.</p> <p>During an interview on [DATE], at 12:01 p.m. Regional Director of Clinical Services Employee E5 confirmed that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs as required.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 211.19(a)(1)(k) Pharmacy services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on review of the clinical records and staff interview, it was determined that the facility failed to provide documentation that medication regimen reviews (MRR) were completed for three of three residents reviewed (Resident R4, R26, and R78).</p> <p>Findings include:</p> <p>Review of facility policy Medication Regimen Review dated 1/2/24, last reviewed 1/12/25, indicated the consultant pharmacist will provide the resident's MRRs to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. The facility should maintain readily available copies of the consultant pharmacists reports on file in the facility, and as part of the resident's permanent health record.</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of Resident R4's physician orders indicated he was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>- Ordered on 4/10/24, Trazodone (an antidepressant) 100 mg (milligrams) at bedtime for insomnia</li> <li>- Ordered 4/10/24, Ziprasidone (an antipsychotic) 40 mg at bedtime for Bipolar Disorder</li> </ul> <p>Review of a pharmacist progress note dated 12/11/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of a pharmacist progress note dated 9/25/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of Resident R4's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 9/25/24, and 12/11/24.</p> <p>Review of the clinical record indicated Resident R26 was admitted to the facility on [DATE].</p> <p>Review of Resident R26's MDS dated [DATE], indicated diagnoses of difficulty swallowing, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and malnutrition (lack of sufficient nutrients to the body).</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a pharmacist progress note dated 12/12/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of Resident R26's physician orders indicated he was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>-Quetiapine (an antipsychotic) 25 mg twice a day for psychosis</li> </ul> <p>Review of Resident R26's clinical record on 1/16/25, failed to reveal the consultant pharmacist report for 12/12/24.</p> <p>Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE].</p> <p>Review of Resident R78's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and malnutrition (lack of sufficient nutrients to the body).</p> <p>Review of Resident R78's physician orders indicated she was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>- Ordered 12/5/24, Escitalopram (an antidepressant) 10 mg daily</li> <li>- Ordered 12/5/24, Divalproex (an anticonvulsant) 125 mg, give four capsules twice a day</li> <li>- Ordered 12/6/24, Mirtazapine (an antidepressant) 15 mg at bedtime</li> <li>- Ordered 12/5/24, Trazodone 100 mg at bedtime</li> </ul> <p>Review of a pharmacist progress note dated 12/6/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of Resident R78's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 12/6/24.</p> <p>During an interview on 1/16/25, at 11:37 a.m. the Director of Nursing confirmed that the facility was unable to locate and provide documentation that medication regimen reviews were completed as required for Resident R4, R26, and R78.</p> <p>28 Pa Code: 201.14 (a ) Responsibility of licensee.</p> <p>28 Pa. Code 211.5(f) Clinical records.</p> <p>28 Pa. Code 211.12(c) Nursing services.</p> <p>28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48546</p> <p>Based on facility policies, clinical record review, and staff interview, it was determined that the facility failed to make certain resident medication regimens were free from potentially unnecessary medications for two of four residents (Residents R4 and R78) and failed to identify a diagnosed specific condition for treatment for one of four residents receiving psychotropic medications (Resident R78).</p> <p>Findings include:</p> <p>Review of facility policy Psychotropic Medication Use dated 1/2/24, last reviewed 1/12/25, indicated psychotropic medications are drugs that affect mood, perception, or behavior, and include but are not limited to antipsychotics, anxiolytics, antidepressants, mood stabilizers or hypnotics. Psychotropic medications should only be prescribed to treat specific conditions as diagnosed and documented in the medical record.</p> <p>Review of facility policy Medication Regimen Review dated 1/2/24, last reviewed 1/12/25, indicated the consultant pharmacist will provide the resident's MRRs to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations. The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. The facility should maintain readily available copies of the consultant pharmacists reports on file in the facility, and as part of the resident's permanent health record.</p> <p>Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE].</p> <p>Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/29/24, indicated diagnoses of high blood pressure, Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life).</p> <p>Review of Resident R4's physician orders indicated he was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>- Ordered on 4/10/24, Trazodone (an antidepressant) 100 mg (milligrams) at bedtime for insomnia</li> <li>- Ordered 4/10/24, Ziprasidone (an antipsychotic) 40 mg at bedtime for Bipolar Disorder</li> </ul> <p>Review of a pharmacist progress note dated 12/11/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of a pharmacist progress note dated 9/25/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R4's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 9/25/24, and 12/11/24.</p> <p>Review of the clinical record indicated Resident R78 was admitted to the facility on [DATE].</p> <p>Review of Resident R78's MDS dated [DATE], indicated diagnoses of Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions), dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and malnutrition (lack of sufficient nutrients to the body).</p> <p>Review of Resident R78's physician orders indicated she was prescribed the following medications:</p> <ul style="list-style-type: none"> <li>- Ordered 12/5/24, Escitalopram (an antidepressant) 10 mg daily. The physician order failed to identify a specific condition for treatment.</li> <li>- Ordered 12/5/24, Divalproex (an anticonvulsant) 125 mg, give four capsules twice a day. The physician order failed to identify a specific condition for treatment.</li> <li>- Ordered 12/6/24, Mirtazapine (an antidepressant) 15 mg at bedtime. The physician order failed to identify a specific condition for treatment.</li> <li>- Ordered 12/5/24, Trazodone 100 mg at bedtime. The physician order failed to identify a specific condition for treatment.</li> </ul> <p>Review of a pharmacist progress note dated 12/6/24, stated, Irregularities/Recommendations noted. See report for any noted irregularities and/or recommendations.</p> <p>Review of Resident R78's clinical record on 1/15/25, failed to reveal the consultant pharmacist report for 12/6/24.</p> <p>During an interview on 1/16/25, at 8:50 a.m. the Nursing Home Administrator confirmed that the facility failed to identify a diagnosed specific condition for treatment for psychotropic medication usage for Resident R78 as required.</p> <p>During an interview on 1/16/25, at 11:37 a.m. the Director of Nursing confirmed that the facility was unable to locate and provide documentation that medication regimen reviews were completed and that the facility failed to make certain resident medication regimens were free from potentially unnecessary medications as required.</p> <p>28 Pa Code 211.5(f) Medical records</p> <p>28 Pa code 211.10(c) Resident care policies</p> <p>28 Pa. 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>46337</p> <p>Based on observation, clinical record review, and staff interview, it was determined that the facility failed to ensure a medication error rate below five percent for two of five residents (Resident R24, and R47).</p> <p>Findings include:</p> <p>The facility's medication error rate was 6.67% (percent) based on 30 medication opportunities with two medication errors.</p> <p>Observation of a medication administration pass on 1/14/25, at 9:40 a.m. revealed Registered Nurse (LPN), Employee E4, failed to administer Resident R47's 305-700mg Potassium phosphate (medication used to make the urine more acidic, preventing kidney stones, as well as odor and rash) timely. Resident R47's medication was scheduled to be administered at 8:00 a.m. LPN, Employee E4 confirmed Resident R47's medication was late.</p> <p>Observation of a medication administration pass on 1/16/25, at 9:26 a.m. revealed LPN, Employee E1, failed to administer Resident R24's Adult 50 Plus 300mcg-250mcg multivitamin. LPN, Employee E15 confirmed the medication was not in stock and not administered as ordered.</p> <p>Interview with the Nursing Home Administrator on 1/16/25, at 6:27 p.m. confirmed the facility failed to ensure a medication error rate below five percent for two of five residents (Resident R24 and R47).</p> <p>28 Pa. Code 211.10(a) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on observations, and staff interviews, it was determined that the facility failed to properly store medications in two out of two medications carts (2B and Unit 1 Medication Carts) and failed to properly store a medication on one of two medication rooms (Unit Medication Room).</p> <p>Findings include:</p> <p>During an observation on [DATE], at 10:16 a.m. of the 2B Medication Cart the following insulin pens failed to be stored correctly:</p> <ul style="list-style-type: none"> <li>-Resident R1's Insulin Glargine pen (prefilled pen used to help control blood sugar, insulin levels, and digestion) was not stored in a bag.</li> <li>-Resident R54's Insulin Glargine pen was not stored in a bag.</li> <li>-Resident R81's Insulin Glargine pen was not stored in a bag.</li> </ul> <p>During an interview on [DATE], at 10:22 a.m. Licensed Practical Nurse (LPN) Employee E15 confirmed the facility failed store Resident R1, R54, and R81's insulin pen correctly.</p> <p>During an observation on [DATE], at 10:23 a.m. Unit one medication cart was observed unlocked and one bottle of 81 milligram (mg) of aspirin and one bottle on Vitamin D3 25 micrograms (mcg) was observed on top of the cart, left unattended.</p> <p>During an observation of Unit 2 Medication Room indicated the following medications and supplies were expired:</p> <ul style="list-style-type: none"> <li>-(38) Hemocult (a test is used to check for blood in your bowel movement) Single Slides-Expired [DATE]</li> <li>-(1) Box COVID-19 Antigen Home Tests-Expired [DATE]</li> <li>-(2) Boxes 30 units/milliliter(ml) Heparin Lock Flushes Expired [DATE]</li> <li>-(1) Ace connector with Legacy Connection Expired [DATE]</li> </ul> <p>During an interview on [DATE], at 10:44 a.m. Registered Nurse, Employee E3 confirmed the above findings.</p> <p>During an interview on [DATE], at 10:50 a.m. the Director of Nursing and Nursing Home Administrator confirmed the facility failed to properly store medications in two out of two medications carts (2B and Unit 1 Medication Carts) and failed to properly store a medication on one of two medications room (Unit Medication Room).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Kittanning Care Drive Kittanning, PA 16201	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code: 211.9(a)(1)(h)(k)(l)(1) Pharmacy services.</p> <p>28 Pa. Code:211.12(d)(1)(2)(3)(5) Nursing services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46167</p> <p>Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to properly store, label and date food products in the Main Kitchen which created the potential for food borne illness.</p> <p>Findings Include:</p> <p>Review of the facility policy Storage of Refrigerated Foods last reviewed 1/12/25, and previously reviewed 1/2/24, indicated that employee lunches shall not be stored in dietary refrigerators.</p> <p>During an observation in the Main Kitchen Back Reach-in Cooler, on 1/12/25, at 9:35 a.m. an opened bottle of Pepsi, and an opened bottle of Dr. Pepper were observed with no name, or date.</p> <p>During an observation in the Main Kitchen Walk-in Freezer, on 1/12/25, at 9:37 a.m. an opened bag of mixed vegetables and an opened package of sausage patties had no date or label.</p> <p>During an observation in the Main Kitchen Dry Storage, on 1/12/25, at 9:45 a.m. an opened bag of corn flake cereal, had no label or date.</p> <p>During an interview completed on 1/12/24, at 9:55 a.m. Food Service Director Employee E10 confirmed the above observations and that the facility failed to properly store, label, and date food in the Main Kitchen which created the potential for food borne illness.</p> <p>28 Pa. Code 201.14(a)Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.6c Dietary services.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on review of facility policies and clinical records and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for three of four residents (Resident R21, R87, and R199)</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R21 was admitted to the facility on [DATE].</p> <p>Review of Resident R21's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/6/24, indicated diagnoses of high blood pressure, hip fracture, and malnutrition (lack of sufficient nutrients to the body).</p> <p>Review of Resident R21's clinical record revealed a physician's order dated 10/31/24, for nifedipine (a drug used to treat high blood pressure or chest pain).</p> <p>Review of this order for Resident R21 did not include a diagnosis for use of this drug.</p> <p>Review of Resident R87's admission record indicated the resident was admitted to the facility 11/15/24.</p> <p>A review of Resident R87's MDS dated [DATE], included diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and morbid obesity due to excess calories.</p> <p>Review of Resident R87's clinical record revealed a physician's order dated 11/15/24, for gabapentin (a drug used to treat seizures or nerve pain).</p> <p>Review of this order for Resident R87 did not include a diagnosis for use of this drug.</p> <p>Review of Resident R199's admission record indicated the resident was admitted to the facility 8/29/24.</p> <p>A review of Resident R199's MDS dated [DATE], included diagnoses of high blood pressure, malnutrition, and pressure ulcer of the right buttock, stage 2 (pressure injury with a partial thickness loss of skin presenting as a shallow open injury with a red/pink wound bed or an intact or open/ruptured serum filled blister).</p> <p>Review of Resident R199's clinical record revealed a physician's order dated 12/24/24, for cefazolin (a drug that used to treat various types of infections).</p> <p>Review of this order for Resident R199 did not include a diagnosis for use of this drug.</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  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  120 Kittanning Care Drive Kittanning, PA 16201	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/25 at 3:08 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E2 confirmed that the facility often fails to select an appropriate diagnosis when entering orders for medications and treatments, which Can be confusing because some drugs do more than one thing. RNAC Employee E2 confirmed that the facility failed to make certain that medical records were complete and accurately documented for Resident R21, R87, and R199.</p> <p>28 Pa. Code: 211.5(f)(g)(h) Clinical records.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46337</p> <p>Based on a review of facility policy, resident clinical records, and staff interview, it was determined the facility failed to obtain a diagnosis, and order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R46).</p> <p>Findings include:</p> <p>Review of the facility Hospice Care Policy dated 5/24/23, and last reviewed 1/12/25, indicated the community provides hospice services through collaboration with a Medicare certified hospice agency when ordered by the resident's physician. Such services will be provided to meet professional standards and be provided timely. The facility will ensure the resident's written plan of care includes both the most recent hospice plan of care and description of the services furnished by the facility to attain and maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. The physician certification and recertification of the terminal illness specific to each resident must be obtained from the hospice agency.</p> <p>Review of the clinical record revealed that Resident R46 was admitted to the facility on [DATE].</p> <p>Review of Resident 46's MDS (Minimum Data Set- periodic assessment of resident care needs) dated 12/20/24, indicated diagnoses of dementia (the loss of cognitive functioning that interferes with daily life and activities), depression, and anxiety. Section O - Special Treatments, Procedures, and Programs indicated hospice care while a resident.</p> <p>Review of Resident R46's clinical record revealed a physician order dated 12/17/24, indicated to admit to hospice, but did not include a diagnosis related to the need of hospice services, or to admit the resident to hospice services.</p> <p>Review of Resident R46's current comprehensive care plan on 1/14/24, at 1:15 p.m. failed to indicate a plan of care by the facility that displayed the coordination of hospice services by failing to include contact information for the hospice agency and how to access the hospice's 24 hour on-call system.</p> <p>During an interview on 1/15/25, at 2:27 p.m. Registered Nurse Assessment Coordinator Employee E2 confirmed that the facility failed to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for Resident R46.</p> <p>Review of Resident R46's hospice communication binder revealed a hospice admission order form dated 12/11/24, that failed to include a physician signature. It was indicated Medicare regulations require that this form be signed and dated by the physician as soon as possible.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/15/25, at 2:51 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to obtain a diagnosis, and order for hospice services and to ensure the coordination of hospice services with facility services to meet the needs of each resident for end-of-life care for one of three residents (Resident R46).</p> <p>28 Pa. Code 211.2(a) Physician services</p> <p>28 Pa. Code 211.11(d) Resident care plan</p>		

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48546</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all the required committee members for one of four quarters (January 2024 through March 2024).</p> <p>Findings include:</p> <p>Review of facility policy Quality Assurance and Performance Improvement (QAPI) Program Policy dated 1/2/24, last reviewed 1/12/25, indicated the facility will maintain a QAPI Committee consisting, at a minimum of, the Administrator, the Director of Nursing Services, the Medical Director or his/her designee, the designated Infection Preventionist, Direct Care staff on a rotating basis, staff from ancillary departments on a rotating basis, and at least two other members of facility staff.</p> <p>A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through March 2024, did not reveal that the Nursing Home Administrator was in attendance.</p> <p>During an interview on 1/16/25 at 2:08 p.m. the Nursing Home Administrator confirmed that the facility failed to conduct QAA meetings at least quarterly with all the required committee members as required.</p> <p>28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.</p>

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<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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46337</b></p> <p>Based on review of facility policies, documentation, observations, resident and staff interviews and state and federal guidance it was determined that the facility failed to implement COVID and Influenza monitoring, tracking, and testing in accordance with state and federal guidance for 95-101 residents from 11/29/24, through 1/15/25. The facility failed to adhere to state return to work guidance for staff. These failures placed all residents in the facility in an Immediate Jeopardy situation.</p> <p>Review of the facility Infection Prevention and Control Program Policy dated 4/16/18, last revised 9/11/23, indicated it is the facility's policy to maintain an organized, effective facility-wide program designed to systemically prevent, identify, control and reduce the risk of acquiring and transmitting infections among employees, volunteers, visitors, and contract healthcare workers, to conduct surveillance of communicable disease and infectious outbreaks, and to monitor employee health. It was indicated employees must follow return to work guidance.</p> <p>Review of the Pennsylvania Department of Health Influenza Outbreaks in Long-Term Care Facilities: Toolkit for Facilities dated 2023-2024, 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> <ul style="list-style-type: none"> <li>-As soon as a respiratory outbreak is suspected, the response should include laboratory testing (i.e., rapid antigen testing, PCR, and/or viral isolation) to evaluate residents and staff and determining the etiology of the outbreak. Specimens should be collected within the first 24-72 hours after symptoms onset and no later than 5 days after symptom onset.</li> <li>-Upon identification of an outbreak, a line listing (designed to collect information about all ill cases for residents and staff during an outbreak of influenza in a long-term care facility) should be utilized to collect and organize information. Information should be updated periodically during the outbreak for all cases.</li> <li>-During an outbreak, conduct daily active surveillance for ILI (influenza-like illness-fever greater than 100F plus cough or sore throat) among residents, staff and visitors to the facility until at least one week after the last confirmed influenza case occurred.</li> <li>-All residents and staff with ILI should receive antiviral treatment immediately; treatment should NOT be delayed while waiting for laboratory confirmation.</li> </ul> <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> <ul style="list-style-type: none"> <li>-Identify and Isolate First Case.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>AND a negative antigen (test used to determine current or recent infection) or Nucleic Acid Amplification Test (NAAT-detects one or more RNA sequences of SARS-CoV-2 and is considered the gold standard for clinical testing. If someone with prior COVID infection within 90 days, antigen testing is recommended) ) is obtained within 48 hours prior to returning to work OR 10 days have passed if testing is not performed or the HCP tests positive at day 5-7;</p> <p>At least 24 hours have passed since last fever without the use of fever-reducing medications; AND</p> <p>Symptoms (e.g., cough, shortness of breath) have improved.</p> <p>Review of resident clinical records and facility documents revealed:</p> <p>Review of Resident R11's clinical record indicated an admitted [DATE], and readmitted [DATE], with diagnoses of heart failure (occurs when the heart muscle doesn't pump blood as well as it should), myopathy (disorders of the muscles that cause them to function less effectively), and chronic kidney disease (disease that involves a gradual loss of kidney function).</p> <p>Review of a report submitted to the Department of Health dated 11/30/24, indicated Resident R11 tested positive for COVID on 11/29/24, while at the hospital. It was indicated as a follow-up action, the facility tested staff prior to the start of their shifts. The COVID Tool Kit will be followed, and a line listing will be developed for tracking purpose. We will also assess any resident, staff, visitors that would be symptomatic during our COVID testing.</p> <p>Review of the facility's COVID tracking log indicated Resident R11 tested positive at the hospital on 12/3/24. The facility failed to accurately track when the COVID outbreak started.</p> <p>Review of Resident R9's clinical record indicated an admitted [DATE], and readmitted [DATE], with diagnoses of Chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), high blood pressure, and bipolar disorder (a mental health condition that causes extreme mood swings).</p> <p>Review of the facility's COVID tracking log revealed Resident R9 tested positive at the hospital on 12/9/24.</p> <p>Review of the facility documents and resident's clinical records revealed residents tested negative on Day 1, Day 3, and Day 5. The facility failed to provide evidence that all residents were monitored for signs and symptoms of COVID after Day 5 (12/15/24) of testing.</p> <p>Review of the facility documents revealed Nurse Aide, Employee E8 tested positive for COVID on 12/25/24.</p> <p>Review of the facility document titled COVID Dec/[DATE] Contact Tracing indicated contact tracing was completed for Nurse Aide, Employee E8 and Residents (R5, R6, R8, R9, R12, R13, R21, R26, R27, R33, R38,R43, R44, R47, R52, R53, R57, R62, R68, R70, R73, R87, R92, R94 R199, R201, R248, R249) were tested on Days 0, 3, and 5 and they were all negative. Review of the facility testing log revealed the facility failed to test residents on Day 1, 12/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of the facility documents revealed Infection Preventionist, Employee E1 tested positive for COVID on 1/8/25.</p> <p>During an observation on 1/14/25, at 11:30 a.m. the signage posted at the facility's entrance stated if staff test positive for a respiratory illness (COVID, Flu, RSV) in the last 10 days, do not enter resident care areas. It was indicated to wait 10 days after the date of the positive test, symptom onset, or exposure to return work.</p> <p>During an interview on 1/14/25, at 12:52 p.m. Infection Preventionist, Employee E1 stated during a COVID outbreak residents are tested on Day 0, 1, 3, and 5. IP, Employee E1 stated if staff members are positive for COVID, they can return to work on the 5th day if they test negative. IP, Employee E1 confirmed she tested positive for COVID on 1/8/25, and returned to work on 1/13/25. IP, Employee E1 confirmed she failed to wait at least seven days since symptoms first appeared and test negative 48 hours prior to returning to work or wait at least 10 days since she tested positive to return to work.</p> <p>During an interview on 1/14/25, at 1:26 p.m. the NHA and Regional Director of Clinical Services, Employee E5 confirmed Infection Preventionist, Employee E1 failed adhere to return to work guidelines.</p> <p>During an interview on 1/15/25, at 10:54 a.m. IP, Employee E1, NHA, and RDCS, Employee E5 confirmed the facility failed to accurately track, test, and monitor resident's during the COVID outbreak.</p> <p>Review of Resident R9's clinical record indicated on 1/3/25, Resident R9 was ordered Guaifenesin (medication used for cough) for a cough. Review of clinical record failed to indicate he was monitored for ILI symptoms or tested for Influenza.</p> <p>Review of Resident R9's progress note dated 1/5/25, indicated Resident R9 requested Robitussin (medication used for cough) for his cough.</p> <p>Review of Resident R9's progress note dated 1/10/25, at 5:15 p.m. indicated Resident R9 was demanding to have an ambulance called to be taken to the emergency room for cold symptoms. The facility staff informed him that the ER is for life-threatening emergencies and that his cold could be treated in house. Resident R9 then requested a breathing treatment.</p> <p>Review of Resident R9's progress note dated 1/11/25, indicated he was sent out to the hospital for behaviors. The resident tested positive for Influenza A at the hospital.</p> <p>Review of Resident R27's clinical record indicated an admitted [DATE], with diagnoses of heart failure, intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), and pneumonia (infection that affects the lungs).</p> <p>Review of Resident R27's progress note dated 1/6/25, indicated the resident complained of stomach pain and hyperemesis (severe nausea and vomiting) that was dark green in color. Resident R27 was sent to the hospital for further evaluation. The facility failed to assess the resident for ILI symptoms and test for Influenza.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of Resident R27's progress note dated 1/7/25, indicated on 1/6/25, the resident returned to the facility and was diagnosed with Influenza A.</p> <p>Review of Resident R52's clinical record indicated an admitted [DATE], and readmitted [DATE], with diagnoses of depression, anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), and dorsalgia (back pain).</p> <p>Review of Resident R52's progress note dated 1/7/25, indicated the resident went to the hospital for a CT scan. RN, Employee E3 received a call from the emergency room that indicated while the resident was at her appointment she became short of breath and had a cough. She was taken to emergency room and tested positive for Influenza A.</p> <p>During an interview on 1/15/25, at 10:48 a.m. Resident R52 stated I was sick for a couple of days before the hospital with nausea and coughing, I don't think they gave me anything for it. I told the nurses I didn't feel well, I had an appointment out of the building and the doctor sent me to ER and that's when they tested me for flu.</p> <p>Review of Resident R52's clinical record failed to indicate the facility assessed the resident for ILI symptoms and test for influenza.</p> <p>Review of Resident R42's clinical record indicated an admitted [DATE], and readmitted [DATE], with diagnoses of heart failure, hypoxemia (low levels of oxygen in your blood, and anemia).</p> <p>Review of Resident R42's progress note dated 1/11/25, at 9:45 a.m. indicated the resident had fever of 102.5 Fahrenheit, audible wheezing, and oxygen saturation was 78% on room air. The facility failed to conduct Influenza testing.</p> <p>Review of Resident R42's progress note dated 1/11/25, at 2:15 p.m. indicated the resident was transferred to the hospital and tested positive for Influenza.</p> <p>Review of facility's Flu [DATE] line listing report for Influenza, revealed Resident R27 tested positive for Influenza A on 1/6/25. Resident R52 tested positive on 1/7/25. The last reported positive cases were on 1/11/25 (Resident R9, R42, and Housekeeper, Employee E9.) The facility was in an Influenza outbreak as of 1/11/25.</p> <p>During an observation on 1/14/25, at 11:30 a.m. the signage posted at the facility's entrance failed to indicate the facility was in an Influenza outbreak.</p> <p>During an interview on 1/14/25, at 11:32 a.m. the Nursing Home Administrator confirmed the signage posted at the entrance of the facility failed to indicate the facility was in an Influenza outbreak.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 1/14/25, at 12:58 p.m. IP, Employee E1 stated Resident R27 was sent to the hospital and tested positive for Influenza on 1/6/24. IP, Employee E1 confirmed Resident R52 was sent out for routine visit and was transferred to hospital for a change in condition and tested positive for Influenza. IP, Employee E1 stated we didn't know she had flu until we sent her and stated she was aware she had respiratory symptoms the whole week prior to sending her out to her appointment. IP, Employee E1 stated she would only test for Influenza if the physician was notified, and it was ordered. IP, Employee E1 confirmed the facility failed to monitor residents for ILI symptoms during an Influenza outbreak and test 4 of 4 Residents who had signs and symptoms of Influenza (Resident R9, R27, R42, and R52).</p> <p>During an interview on 1/15/25, at 11:07 a.m. the NHA and RDCS, Employee E5 confirmed the facility failed to test four of four residents for Influenza who had symptoms (Resident R9, R27, R42, and R52). The NHA confirmed no residents were tested for Influenza in the facility.</p> <p>During an interview on 1/15/25, at 2:49 p.m. the Nursing Home Administrator (NHA), Director of Nursing (DON), and RCDS Employee E5 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 1/15/25, at 5:47 p.m. an acceptable Corrective Action Plan was received, which included the following interventions:</p> <p>Issue #1</p> <p>-Facility immediately initiated monitoring signs and symptoms for residents with COVID.</p> <p>IP/Designee will conduct house audit of residents with signs and symptoms of COVID by EOD 1/16/25.</p> <p>-Regional Director of Clinical Services will conduct in-service regarding Infection Control and Outbreak Response to facility Infection Preventionist and Director of Nursing by 1/16/25.</p> <p>-IP/Designee will conduct education to all staff regarding infection control measures and monitoring at their start of shift beginning 1/15/25 and before next shift by EOD 1/16/25.</p> <p>-To prevent reoccurrence, DON/Designee will conduct audits to monitor for resident's signs and symptoms for COVID, daily x5 days for 14 days , then weekly for 4 weeks then monthly x2.</p> <p>-Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>Issue #2</p> <p>-Effective 1/15/25, facility will ensure that COVID testing occurs on Day 1 following a positive result in accordance with PA DOH COVID 19 Infection Control Outbreak Response Toolkit for Long Term Care.</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  01/16/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>-IP/Designees will conduct house audit of all COVID testing to ensure Day 1 testing complete upon positive result by EOD 1/16/25.</p> <p>-Regional Director of Clinical Services will conduct in-service regarding Infection Control and Outbreak Response testing procedures to facility Infection Preventionist and Director of Nursing by 1/16/25.</p> <p>-IP/Designee will conduct education to all staff regarding Infection Control and Outbreak Response testing procedures at their start of beginning 1/15/2025 and before next shift by EOD 1/16/25.</p> <p>-To prevent reoccurrence, DON/Designee will conduct audits to monitor for completion of Day 1 testing for positive COVID results, daily x5 days for 14 days , then weekly for 4 weeks then monthly x2.</p> <p>-Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>Issue #3</p> <p>-Effective 1/15/25, facility will ensure that return to work guidance for a staff member who tested Outbreak Response Toolkit for Long Term Care.</p> <p>-IP/Designee will monitor for any COVID positive staff weekly x4 weeks, monthly x2 months, and ongoing with occurrence, to ensure that return to work guidance for a staff member who tested positive for COVID is followed.</p> <p>-IP/Designee will conduct education regarding return to work guidance for a staff member who tested positive for COVID is followed in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care beginning 1/15/2025 and before next shift by EOD 1/16/25.</p> <p>-To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for COVID positive staff and monitor return to work status, weekly with outbreak occurrence in accordance with PA DOH COVID 19 Infection Control and Outbreak Response Toolkit for Long Term Care by 1/16/25.</p> <p>-Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>Issue #4</p> <p>-Effective 1/15/2025, IP/Designee to ensure that residents exhibiting signs and symptoms of Influenza are monitored in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>-IP/Designee will monitor all residents weekly x 4 weeks, monthly x 2 months and ongoing with occurrence for any sign and symptoms of Influenza in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care.</p> <p>-Regional Director of Clinical Services will conduct Inservice regarding identification of Influenza signs and symptoms and testing in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25.</p> <p>-IP/Designee will conduct education to all staff regarding identification of Influenza signs and symptoms and testing in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care beginning 1/15/2025 and before next shift by EOD 1/16/25.</p> <p>-To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for Influenza signs and symptoms and testing, weekly with occurrence in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25.</p> <p>-Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed.</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>Issue #5</p> <p>-Effective 1/15/2025, IP/Designee will conduct an initial audit of all residents ' temperatures to ensure that residents exhibiting signs and symptoms of Influenza are monitored in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care.</p> <p>-IP/Designee will monitor all residents ' temperatures weekly x 4 weeks, monthly x 2 months and ongoing with occurrence for any sign and symptoms of Influenza in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care.</p> <p>-Regional Director of Clinical Services will conduct Inservice regarding identification of Influenza signs and symptoms and monitoring in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/25.</p> <p>-IP/Designee will conduct education to all staff regarding identification of Influenza signs and symptoms and monitoring in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care beginning 1/15/25 and before next shift by EOD 1/16/25.</p> <p>-To prevent reoccurrence, DON/Designee will conduct ongoing monitoring for Influenza signs and symptoms, weekly with occurrence in accordance with the PA DOH Influenza Outbreak Response Toolkit for Long Term Care by 1/16/2025.</p> <p>-Negative findings will be addressed. Policies and Procedures to be reviewed and updated as needed. Ad Hoc education will be provided as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Review of medical records and facility documents on 1/16/25, revealed 98 of 98 residents were assessed for signs and symptoms of Influenza and COVID. No residents exhibited IFI symptoms and required Influenza testing. The facility obtained Influenza tests from hospital and were available for staff to use if needed. Facility wide testing was conducted on all residents and staff prior to the start of their shift for COVID. The DON completed an audit of tests and no positive COVID results were identified. The facility will conduct COVID testing until Day 5, then monitor residents and staff for signs and symptoms of COVID, and test as needed, until Day 14.</p> <p>Review of facility documents revealed the policy for Managing respiratory Illnesses and Outbreaks and Investigating Communicable Outbreaks was created 1/16/25.</p> <p>During an observation on 1/16/25, at 9:02 a.m. the signage posted at the entrance of the facility indicated the facility was currently in an influenza and COVID outbreak.</p> <p>Review of facility documents on 1/16/25, revealed the Regional Director of Clinical Services, Employee E5 conducted an in-service with the Infection Preventionist, Employee E1, and the Director of Nursing on 1/15/25.</p> <p>Review of facility documents on 1/16/25, revealed that the facility had 104 employees and 100% had received education on the facility's COVID-19 and Influenza infection control practices and outbreak response. 48 of these employees received formal education on the facility's COVID-19 infection control practices. 56 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 1/16/25, between 2:45 p.m. and 3:02 p.m. 28 employees confirmed that they received education on the facility's COVID-19 and Influenza infection control practices and outbreak response. 21 of these employees had received education in person and seven of these employees had received education over the telephone and signed the training sheet prior to the start of their shift.</p> <p>The Immediate Jeopardy was lifted on 1/16/25, at 5:49 p.m. when the action plan implementation was verified.</p> <p>During an interview on 1/16/25, at 6:39 p.m. the Nursing Home Administrator confirmed that the facility failed to implement COVID and Influenza monitoring, tracking, and testing in accordance with state and federal guidance for 95-101 residents from 11/29/24, through 1/15/25. The facility failed to adhere to state return to work guidance for staff. These failures placed all residents in the facility in an Immediate Jeopardy situation.</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>		