

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 01/09/2026
NAME OF PROVIDER OR SUPPLIER Kittanning Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Kittanning Care Drive Kittanning, PA 16201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, resident interview, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for two of six residents reviewed (Resident R31, and R53) which resulted in actual harm (a medication overdose that caused unresponsiveness and required the administration of Narcan- a medication used to reverse overdoses of opioids [pain medication with a high risk of addiction] that is administered via a nasal spray) for Resident R31. Findings include: Review of facility policy General Dose Preparation and Medication Administration dated 6/18/25, stated prior to administration of medication, facility should verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the resident. Review of the clinical record revealed that Resident R31 was admitted to the facility on [DATE]. Review of Resident 31's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 12/23/25, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and pain. Review of Resident R31's Nurse Practitioner progress note dated 4/3/25, at 11:56 a.m. indicated that Resident R31 was seen per staff request following patient requiring to have 1 mg (milligram) of Narcan due to unresponsiveness. Per staff resident asked for diazepam (medication used to treat anxiety), around midnight. He was given oxycontin (an opioid pain medication containing oxycodone that is slow released over a 12-hour period) by error which was discovered during pill count at end of shift this morning. He also received his regular two Percocet (an opioid pain medication containing oxycodone and acetaminophen) at 12:31 a.m. and one Percocet at 7:31 a.m. When going to retrieve his lunch tray staff found him lying face down on his bed. He was not waking up easily. Supervisor gave him 1 mg Narcan and, at that time resident had a pulse, and was coming around awake, and talking. Continues to feel drowsy and is complaining of a dry mouth. Vitals are stable. Patient not to receive any further narcotics today. Will reevaluate orders. Review of a written statement from Licensed Practical Nurse (LPN) Employee E28 dated 4/3/25, stated I'm trying to do everything so perfectly that I'm seeming to be making mistakes instead. If I would have only gave the resident his Valium when I moved the card to the right spot this surely wouldn't of happened. Review of Resident R31's clinical record revealed that resident was not ordered oxycontin. During an interview on 1/7/26, at 7:48 a.m. Resident R31 stated They overdosed me on pain meds. I'm (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0760 Level of Harm - Actual harm Residents Affected - Few	on Percocet, and I asked for Valium. They gave me someone else's pain meds, and they had to Narcan me During an interview on 1/8/26, at 9:23 a.m. LPN Employee E10 stated that she worked the day that Resident R31 was overdosed and had to be administered Narcan. She stated that LPN Employee E28 Realized the count (number of drugs) was off, and she said she couldn't afford to make a mistake. The resident went unresponsive. It was terrifying. You have to read the MAR (medication administration record - a document used to track and record the administration of medications), double check the med cart, and if you're confused you need to clarify. You need to make sure you have the right resident, and the right med. The med card has a resident name on it. During an interview on 1/7/26, at 9:32 a.m. LPN Employee E25 stated that she was aware of the above incident, and that you have to double check everything when you give medications, including the resident, the medications, the dose, the route, and the time. It was a bad mistake because he already received a medication that included oxycodone and then got another dose of it that wasn't his, with an extended release. During an interview on 1/8/26, at 12:24 p.m. the Regional Nurse Consultant Employee E1 confirmed the facility failed to ensure that residents were free from any significant medication errors for Resident R31 which resulted in harm. Review of the clinical record indicated Resident R53 was admitted to the facility on [DATE]. Review of Resident R53's MDS dated [DATE], indicated diagnoses of high blood pressure, depression, and diabetes. Review of Resident R53's care plan dated 3/7/25, indicated to administer diabetic medications and insulin as per orders. Review of a physician order dated 5/9/25, indicated to administer insulin lispro 100 unit/ml (units per milliliter), 12 units with breakfast and dinner plus sliding scale, twice a day. During an observation on 1/6/25, at 9:13 a.m. of Resident R53's medication pass, Licensed Practical Nurse (LPN), Employee E27 failed to prepare or administer Resident R53's insulin. During an interview on 1/6/25. at 9:14 a.m. Resident R53 confirmed she already ate breakfast and did not receive insulin. During an interview on 1/6/25, at 9:15 a.m. LPN, Employee E27 confirmed Resident R53's insulin was not administered as ordered. During an interview on 1/6/25, at 10:38 a.m. the DON confirmed that the facility failed to ensure that residents are free of significant medication errors for one of six residents reviewed (Resident R53) as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of facility documents, and resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of eleven of 16 residents (Group Resident (GR)1, GR2, GR3, GR4, GR5, GR6, GR7, GR8, and GR9, R51, and R88). Findings Include: Review of Payroll Based Journal (PBJ- a mandatory reporting system for nursing homes in which staffing information is reported on a quarterly basis) dated 1/1/25, through 3/31/25, indicated that the facility has a one star rating out of five stars, and that they have excessively low weekend staffing. Review of PBJ dated 7/1/25 through 9/30/25, indicated that the facility has a one star rating out of five stars, and that they have excessively low weekend staffing. During an interview on 1/6/26, at 9:52 a.m. Resident R88 stated that he is supposed to get two showers a week, and that he requires two employees for him to get a shower. I don't always get a shower as they don't always have two employees to shower me. During a resident council group interview on 1/6/26, at 1:00 p.m. nine out of nine residents voiced that the facility is short staffed. During an interview on 1/7/25, at 7:57 a.m. Resident R51 stated I'm supposed to get a shower twice a week and I'm lucky if I get one. I'm told it's because they don't have enough staff. During an interview on 1/8/26, at 9:32 a.m. Licensed Practical Nurse (LPN) Employee E25 confirmed that the facility does not have enough staff. Three to eleven shift is bad. They [residents] don't get showers then. During an interview on 1/8/25, at 10:34 a.m. Nurse Aide (NA) Employee E26 also stated that they do not have enough staff. Today I have to skip a shower because of no staff. It happens several times a week but has been worse in the past month. All shifts appear to be short. It's just hard in general, can't get people out of bed, hard to find help for Hoyer lifts (a mechanical device used to safely transfer individuals who cannot move independently and requires two employees for safe operation), and tray pass takes longer. During an interview on 1/8/26, at 10:25 a.m. the Director of Nursing confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for eleven of 16 residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(6) Management. 28 Pa. Code: 211.12(d)(1)(4) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews it was determined that the facility failed to ensure that fit testing of NIOSH-approved N-95 masks (a respirator mask used to care for residents with suspected or confirmed Covid-19) was completed to care for residents with suspected or confirmed Covid-19 (an infectious disease caused by a virus) during an outbreak in order to prevent the transmission of communicable diseases and infections during a COVID-19 outbreak from 12/29/25 through 1/9/26, and failed to properly monitor residents refrigerator temperatures for one of two residents (Resident R88). Findings include: A review of facility policy Respiratory Protection dated 6/18/25, indicated that it is designed to protect employees by establishing accepted practices for respirator use. The infection preventionist or designee is responsible for the implementation with training, oversight, medical evaluation procedures, annual review, and enforcement of the policy. Employees have responsibilities to wear their respirator when required to. Fit Testing: The Infection Preventionist and at least one backup will be the designated fit test administrators at the facility. Fit testing administrators will complete applicable training before administering fit testing to employees. Fit testing: A procedure to ensure a tight- fitting respirator forms a proper seal on a person's face. Review of the Pennsylvania Department of Health Bureau of Epidemiology, Respiratory Virus Outbreak Toolkit dated 9/25/25, revealed the following: Masking The long-term care facility should encourage masking of health care providers, residents, and visitors during any respiratory virus outbreak. This provides protection for the wearer and protection for others. When masking, the masks: Should be well-fitting with minimal gaps Should cover both nose and mouth Should be changed if they become soiled, damaged, or had to breathe through Health Care Providers working with suspected of confirmed COVID residents should use fit-tested, NIOSH-approved N95's. Review of the facility policy Food Brought in From Outside the Facility dated 6/18/25, indicated that the refrigerator where the food will be stored will have an internal thermometer. Units will maintain safe internal temperatures in accordance with state and federal standards for safe food storage temperatures. Temperatures will be monitored daily. Residents with personal refrigerators will be assisted by staff in ensuring their personal unit is in compliance with all of the above storage guidelines. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During entrance into the facility on 1/5/26, at 9:00 a.m. a notification of facility having a COVID outbreak was observed hanging on the front door. During an interview on 1/5/26, at 9:15 a.m. the Regional Nurse Consultant/Infection Preventionist Employee E1 confirmed that the facility had positive cases of COVID and were in an outbreak. During a review of documentation provided by facility on 1/5/26, at 9:30 a.m. 11 out of 29 residents were in isolation precaution for positive COVID tests results or being exposed to someone with COVID. During a tour of the facility on 1/5/26, at 9:30 a.m. Isolation signs and Personal Protective Equipment (PPE) were hanging on exposed or confirmed COVID resident's door. During a tour of unit one from 1/5/26, through 1/9/26, N95's were observed being worn by staff to provide care for exposed or confirmed COVID residents. During an interview on 1/6/26, at 10:20 a.m. Regional Nurse Consultant/Infection Preventionist Employee E1 stated that the facility has not fit tested any staff for N-95 respirators since working at the facility, which has been since March 2025. We do not have anyone trained to fit test staff for N-95's at the facility and that staff are not wearing fit tested N-95's to provide care and treatment to residents who are exposed or are confirmed with COVID. During an interview on 1/9/26, at 10:00 a.m. Registered Nurse Employee E13 stated, Not here, No I haven't been fit tested, and I take care of residents who are COVID positive. During an interview on 1/9/26, at 10:03 a.m. Licensed Practical Nurse Employee E14 stated, I have not been fit tested for a N-95 at the facility. I take care of positive COVID residents. During an interview on 1/9/26, at 10:06 a.m. Nurse Aide Employee E7 stated, No, I have not been fit tested for a N-95. I go into all the COVID rooms to care for the residents. We have to wear a gown, googles, gloves, and N-95's to enter the room. During an interview on 1/9/26, at 1:00 p.m. Regional Nurse Consultant/Infection Preventionist Employee E1 confirmed that the facility failed to ensure that fit testing of NIOSH-approved N-95 masks was completed in order to care for residents with suspected or confirmed Covid-19 during an outbreak in order to prevent the transmission of communicable diseases and infections during a COVID-19 outbreak from 12/29/25 through 1/9/26. Review of the clinical record revealed that Resident R88 was admitted to the facility on [DATE]. Review of Resident 88's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/12/25, indicated diagnoses of high blood pressure, thyroid disorder, and chronic pain. During an observation on 1/6/26, a Refrigerator Temperature Log was posted on Resident R88's wall above his personal refrigerator. Review of the Refrigerator Temperature Log had dates for September 2025, and October 2025. September 2025 did not have temperatures recorded on 9/6/25, 9/7/25, 9/8/25, 9/9/25, 9/12/25, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	9/13/25, 9/14/25, 9/20/25, 9/21/25, 9/22/25, 9/24/25, 9/26/25, 9/29/25, 9/30/25 (missing 14 out of 30 days) October 2025 had no data recorded for the whole month (missing 31 out of 31 days). During an interview on 1/8/26, at 12:25 p.m. the Director of Nursing confirmed that there were no Refrigerator Temperature logs kept for November 2025, and December 2025, which indicated that there was missing data for 30 out of 30 days for November 2025, and missing data for 31 days out of 31 days for December 2025, and that the facility failed to monitor refrigerator temperatures as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3)(d)(e)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for two of two of the facilities crash carts (a cart that contains supplies in the event of an emergency), (Common Room and Memory Impaired Unit) and two of two Automated External Defibrillator (AED-a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias), (Common Room and Main Dining Room).Findings include:Review of facility Emergency Equipment Check policy dated [DATE], indicated the emergency equipment will be checked daily and items which are outdated or opened will be replaced. The cart will be re-stocked promptly after any use.During a review of facility provided document labeled Emergency Cart Daily Checklist of the facilities crash cart (common room) on [DATE], at 10:30 a.m. revealed missing signatures for [DATE], and [DATE].The Emergency Cart Daily Checklist indicated that if AED on site, check battery life and presence of pads daily.During an observation of the facilities crash cart, located in the common room, on [DATE], at 10:35 a.m. revealed the following supplies to be expired:(3) suctioning tubing - expired [DATE](1) Ambu bag (a handheld manual resuscitator used to provide positive pressure ventilation) was opened and had a date of 07/2015 on the package.During an interview on [DATE], at 10:40 a.m. Registered Nurse Employee E13 confirmed the above missing signatures, expired supplies, and that AED battery checks were missing.During an observation of the facilities crash cart, located in Memory Impaired Unit, on [DATE], at 10:40 a.m. revealed the following supplies to be expired:(1) Continu-Flo Solution IV tubing - expired [DATE](2) IV start kits - expired [DATE](3) suction tubing - expired [DATE]During an interview on [DATE], at 10:48 a.m. Licensed Practical Nurse Employee E12 confirmed the expired supplies on Memory Impaired Unit crash cart.During an interview on [DATE], at 1:00 p.m. the Director of Nursing confirmed that the facility failed to make certain that equipment was in safe operating condition for two of two of the facilities crash carts (Common Room and Memory Impaired Unit) and two of two Automated External Defibrillator (Common Room and Main Dining Room).28 Pa Code: 201.14(a) Responsibility of licensee.		

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on clinical record review and family and staff interview, it was determined that the facility failed to provide quarterly resident trust fund statements for four of four sampled residents (Residents R11, R31, R80, and Residents R88). Findings include: The facility Resident fund management policy dated 6/10/25, indicated that quarterly statements are to be sent by corporate office and addresses are to be maintained in the resident fund management system. During a resident council group interview on 1/6/26, at 1:00 p.m. three out of nine residents voiced that the facility has not provided them with quarterly statements. Review of the facility trust fund account (resident funds account with current accounts open and holding resident monies) dated 1/6/25, indicated the following residents had active resident fund accounts: Residents R11, R31, R80, and Residents R88. Further review of facility business records and resident records for did not include evidence that the residents were provided quarterly statements. During an interview on 1/7/26, at 12:55 p.m. Business office manager Employee E15 confirmed that the facility could not provide evidence of sending quarterly statements and the facility failed to provide a quarterly resident fund statements for Residents R11, R31, R80, and Residents R88 as required. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights		

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, closed clinical records, resident fund account statements and staff interview it was determined that the facility failed to convey resident funds and close accounts upon discharge within 30 days for three out of three closed resident records (Closed Resident records CR110, CR111, and CR112). Findings include: The facility Resident fund management policy dated [DATE], indicated that trust accounts for discharged or expired residents are to be closed and funds disbursed timely. Review of Closed Resident Record CR110's admission record indicated he was admitted on [DATE] and re-admitted to the facility on [DATE]. Review of Closed Resident Record CR110's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated [DATE], indicated he was admitted with diagnoses that included dementia (a condition characterized by memory loss and progressive or persistent loss of intellectual functioning), depression (a state of consistent sadness and loss of interest interfering in daily life activities), anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry) and restlessness. Review of Closed Resident Record CR110's physician orders dated [DATE], indicated to release CR110's body to the funeral home. Review of Closed Resident Record CR110's clinical progress documentation dated [DATE], indicated CR110 ceased to breathe. Hospice notified resident expired. Review of Closed Resident Record CR111's admission record indicated she was admitted on [DATE]. Review of Closed Resident Record CR111's MDS assessment dated [DATE], indicated she had diagnoses that included dementia, hypertension (a condition impacting blood circulation through the heart related to poor pressure), and Takotsubo syndrome (sudden temporary weakening in the heart muscle). Review of Closed Resident Record CR111's clinical nurse notes dated [DATE], staff called to CR111's room and she was observed for two minutes with no audible pulse. Review of Closed Resident Record CR111's physician note dated [DATE], indicated to release CR111 body to morgue or funeral home. Review of Closed Resident Record CR112's admission record indicated she was admitted on [DATE]. Review of Closed Resident Record CR112's MDS assessment dated [DATE], indicated she had diagnoses that included lumbar fracture, hypertension and chronic pain. Review of Closed Resident Record CR112's clinical nurse notes dated [DATE], indicated staff heard a noise and went into CR112's room at 8:39 a.m. CR112 was observed sitting by her roommate bed and bleeding from back of head. Other staff called and applied compressing dressing. CR112 stated she was trying to [NAME] the bathroom. CR112 was sent to the hospital. Review of Closed Resident Record CR112's physician order dated [DATE], indicated CR112 may discharge to other nursing facility. Review of the facility trust fund account (resident funds account with current accounts open and holding resident monies) dated [DATE], indicated the following: Closed Resident Record CR110 had a balance of \$108.60Closed Resident Record CR111 had a balance of \$79.50Closed Resident Record CR112 had a balance of \$20.03 During an interview on [DATE], at 11:13 a.m. the Business office manager Employee E15 confirmed that the facility failed to convey resident funds and closed resident accounts within 30 days upon discharge for Closed Resident Record CR110, CR111, and CR112 as required. 28 Pa. Code 211.5(d) Clinical records.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, staff interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of five residents (Resident R13, R36, and R100). Findings include: Review of facility policy Oxygen Administration dated 6/18/25, indicated licensed clinicians with demonstrated competence will administer oxygen via specified route as ordered by physician. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/3/25, indicated diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), asthma (condition where the airways narrow and swell), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. Review of a physician's orders dated 10/29/25, indicated to administer oxygen via nasal cannula (a thin tubing that delivers oxygen from the oxygen concentrator to the nose) two liters per minute as needed for shortness of breath. During an observation on 1/5/26, at 10:45 a.m. Resident R13 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. Oxygen tubing was dated 12/15/25. Review of the clinical record indicated Resident R36 was admitted to the facility on [DATE]. Review of Resident R36's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and asthma. Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. Review of physician's orders dated 4/21/25, indicated to administer oxygen via nasal cannula at two liters per minute at bedtime as needed for comfort. During an observation on 1/5/26, at 10: 50 a.m. Resident R36 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. The oxygen tubing failed to have a date when it was changed. The humidification was connected to the concentrator and failed to have a date which it was put on for use. Review of the clinical record indicated Resident R100 was admitted to the facility on [DATE]. Review of Resident R100's MDS dated [DATE], indicated diagnoses of COPD, asthma, and heart failure (a progressive heart disease that affects pumping action of the heart muscles). Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident. Review of a physician's orders dated 1/31/25, indicated to administer oxygen via nasal cannula three liters per minute continuously. Add humidification for comfort, if needed. Review of physician's orders dated 11/24/25, indicated to administer ipratropium-albuterol (a medication used to open air ways in the lung) via nebulizer (a machine used to deliver inhaled medication using tubing and handheld device) every four hours as needed. During an observation on 1/5/26, at 10:55 a.m. Resident R100 was lying in bed with oxygen in use. The oxygen concentrator was located beside the bed. The oxygen tubing was dated 12/15/25, and the humidification bottle was empty and failed to have a date on which it was put on for use. The nebulizer machine was observed on the bedside stand. The nebulizer tubing was dated 11/11/25, and was not stored in a bag when not in use. During an interview on 1/5/26, at 11:21 a.m. Licensed Practical Nurse (LPN) Employee E3 stated that the oxygen and nebulizer tubing should be changed weekly and stored in a bag when not in use. I was taught to date everything. How would you know when it was changed? and confirmed the above findings. During an interview on 1/5/26, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to provide appropriate respiratory care for three of five residents (Resident R13, R36, and R100). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to ensure a physician response for medication regimen reviews (MRR) for four of six sampled resident records (Resident R2, R5, R9, and R71). Findings include: The facility Medication Regimen Review policy last reviewed 6/18/25, indicated that the drug regimen review of each resident is completed at least monthly by the consultant pharmacist and any irregularities are reported. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the Director of Nursing to act upon recommendation contained in MRR. For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations and provide and explanations as to why recommendation was rejected. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/14/25, indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and wound infection. Review of Resident R2's MRR in the clinical record on 1/8/26, at 9:00 a.m. indicated the following: November 2025 - facility failed to provide the completed MRR by attending physician December 2025 - facility failed to provide the completed MRR by attending physician Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Resident R5's MRR in the clinical record on 1/8/26, at 9:10 a.m. indicated the following: June 2025 &ndash; facility failed to provide the completed MRR by attending physician July 2025 &ndash; facility failed to provide the completed MRR by attending physician August 2025 - facility failed to provide the completed MRR by attending physician September 2025- facility failed to provide the completed MRR by attending physician October 2025 - facility failed to provide the completed MRR by attending physician (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of heart failure, diabetes, and anxiety. Review of Resident R9's MRR in the clinical record on 1/8/26, at 9:20 a.m. indicated the following: February 2025 &ndash; facility failed to provide the completed MRR by attending physician March 2025 &ndash; facility failed to provide the completed MRR by attending physician September 2025 - facility failed to provide the completed MRR by attending physician October 2025- facility failed to provide the completed MRR by attending physician November 2025 - facility failed to provide the completed MRR by attending physician December 2025 - facility failed to provide the completed MRR by attending physician Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's MDS dated [DATE], indicated diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease (a degenerative brain disease that affects muscle control, among other symptoms), and depression. Review of Resident R71's medication regimen reviews (MRR) dated 12/18/25, revealed the resident has received Phenazopyridine (a medication used to treat symptoms of a urinary tract infection) for symptomatic relief of dysuria (painful or uncomfortable urination) greater than two days. Prolonged use may mask the symptoms of unresolved cystitis and increase the risk of complications. Recommendations indicated to please discontinue Phenazopyridine. A further review of Resident R71's MRR dated 12/18/25, failed to include a physician's response as required. During an interview on 1/7/26, at 12:59 p.m. the Director of Nursing and the Regional Nurse Consultant, Employee E1 confirmed that the facility failed to provide documentation of medication regimen reviews (MRR) were signed by physician for Resident R71. During an interview on 1/8/26, at 9:30 a.m. the Director of Nursing confirmed that the facility failed to ensure MRR's were completed by the facility for four of six residents (Resident R2, R5, R9, and R71). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on review of facility in-service documentation, personnel files, and staff interviews it was determined that the facility failed to implement and maintain an effective training program for three out of five personnel files reviewed (Licensed Practical Nurse (LPN) Employee E10, Nurse Aide (NA) Employee E11, and LPN Employee E12). Findings include: Review of LPN Employee E10's personnel file indicated a date of hire on 10/2/23. Review of LPN Employee E10's personnel file did not include annual in-service training on Effective Communication, Resident Rights, Abuse, QAPI (Quality Assurance and Performance Improvement), Infection Control, Compliance and Ethics, and Behavioral Health from 1/1/25 through 12/31/25. Review of NA Employee E11's personnel file indicated a date of hire on 7/1/23. Review of NA Employee E11's personnel file did not include annual in-service training on Effective Communication, Resident Rights, Abuse, Infection Control, Compliance and Ethics, and Behavioral Health from 1/1/25 through 12/31/25. Review of LPN Employee E12's personnel file indicated a date of hire on 7/1/23. Review of LPN Employee E12's personnel file did not include annual in-service training on QAPI and Behavioral Health from 1/1/25 through 12/31/25. During an interview on 1/7/26, at 11:31 a.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to implement and maintain an effective training program for three out of five personnel files reviewed (LPN Employee E10, NA Employee E11, and LPN Employee E12). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a)(d) Staff development.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations and staff interviews, it was determined that the facility failed to determine whether it was safe to self-administer medications for one of four residents (Resident R77). Findings include: Review of the facility policy Self-Administration of Medications dated 6/18/25, indicated facility should comply with policy with respect to resident self-administration of medications. The facility should assess and determine whether self-administration of medications is safe and clinically appropriate, based on the resident's functionality and health condition. Facility should ensure that orders for self-administration list the specific medications the resident may self-administer. Review of the clinical record indicated Resident R77 was admitted to the facility on [DATE]. Review of resident R77's Minimum Data Set (MDS-a periodic assessment of care needs) dated 10/17/25, indicated the diagnoses of high blood pressure, Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). During an observation on 1/5/26, at 10:17 a.m. Resident R77 was sitting on the edge of the bed with a bedside table. On the bedside table included a paper towel with 10 medication pills laying on top. Medications included: four white pills, two yellow pills, two red pills, one peach pill, and one pink pill. No nurse was observed in the room at this time. Review of Resident R77's physician orders failed to include an order for self-administration of medications. Review of Resident R77's care plan failed to address self-administration of medications. During a review of facility provided documentation labeled Self-Administration of Medications dated 11/30/25, indicated that resident did not want to self-administer medications. During an interview on 1/5/26, at 10:21 a.m. Licensed Practical Nurse (LPN) Employee E3 stated We should not leave medications in a resident's room. We are supposed to watch them take them. and confirmed the unsecured medications at bedside for Resident R77. During an interview on 1/9/26, at 10:09 a.m. LPN Employee E14 stated, I watch residents take medication. I would not leave medications in room for them to take. There is too much liability against my license. It's not safe for residents. Other residents could take the medication. The resident may not take the medication. During an interview on 1/5/26, at 2:00 p.m. the Director of Nursing confirmed the facility failed to determine whether it was safe to self-administer medications for one of four residents (Resident R77). 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code: 211.12(d)(1)(5) Nursing services		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record review, and staff interviews, it was determined that the facility failed to ensure the physician was appropriately notified of change in condition for one of four residents reviewed (Resident R99). Findings include: Review of the facility Resident Change in Condition policy dated 6/18/25, stated for physician and family will be notified as soon as the nurse had identified the change in condition and the resident is stable. Review of the clinical record indicated Resident R99 was admitted to the facility on [DATE]. Review of resident R99's care plan dated 8/19/25, indicated to notify physician of any changes. Review of Resident R99's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/22/25, indicated diagnoses of dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), anxiety, and depression. Review of Resident R99's progress note dated 9/4/25, at 10:18 p.m. stated During evening care resident began swinging at the staff and then started to punch himself on his head. No injuries noted at this time and resident has been redirected and placed at the nursing station for monitoring. Review of Resident R99's clinical record failed to reveal evidence the resident's physician was notified of the change in condition on 9/4/25. Review of Resident R99's progress note dated 10/13/25, at 10:18 p.m. stated Multiple times throughout the evening resident stating he wants to die, asking staff to kill him, hitting self on his head. Review of Resident R99's clinical record failed to reveal evidence the resident's physician was notified of the change in condition on 10/13/25. During an interview on 1/8/26, at 10:52 a.m. information was disseminated to the Regional [NAME] President of Operations, Employee E17, that the facility failed to ensure the physician was appropriately notified of change in condition for one of four residents reviewed (Resident R99). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, facility documents, clinical records, incident investigations, and staff interviews, it was determined that the facility failed to ensure that residents are free from misappropriation of property for one of two residents (Resident R88). Findings include: Review of the facility policy Pennsylvania Resident Abuse dated 6/18/25, indicated that the facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone. Exploitation was defined as the unfair treatment or use of a resident or the taking of a selfish or unfair advantage of a resident for personal gain, through manipulation, intimidation, threats or coercion. Review of the clinical record revealed that Resident R88 was admitted to the facility on [DATE]. Review of Resident 88's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/12/25, indicated diagnoses of high blood pressure, thyroid disorder, and chronic pain. Review of a written statement dated 12/24/25, revealed that Business Office Manager (BOM) Employee E15 stated the following: As I was reviewing the RFMS (Resident Fund Management Service- banking account information) account for Resident R88 on 12/24/25, I noticed a check issued to Nurse Aide Employee E29 in the amount of \$750 on April 22, 2025. I asked the resident who this person was and why he asked for the check to be issued as it was over the \$500 Medicaid gifting limit. The resident stated, 'That is a nurse aide from here (the facility) who was having a rough time, and I felt bad and wanted to help.' I then informed the resident that he was a very generous person however; employees are not permitted to receive gifts of any kind from residents. Review of the RFMS report for Resident R88 that was ran on 12/30/25, and included transactions from 1/1/25, through 12/30/25, indicated that two checks were written on 4/22/25, for the amount of \$750. One was for NA Employee E29, and NA Employee E30. The RFMS report also stated that the checks were cashed and cleared on 4/25/25. During an interview on 1/6/25, at 9:54 a.m. Resident R88 stated that he Gave two employees \$750, and they got fired. I feel so bad. During an interview on 1/7/25, at 2:54 p.m. BOM Employee E15 was asked if the resident is able to write his own checks from the RFMS account. BOM Employee E15 stated No. He would have had to gotten the former BOM to write a check from that account. He (Resident R88) called me and asked me to write him a check for his credit union for \$750. I told him that anything over \$500 gets questioned by Medicaid and advised him to keep it under 500. That's when I checked his account and saw that he had written other checks for \$750 (to NA Employee E29, and E30). BOM Employee E15 was asked if the former BOM should have advised him not to write a check out to employees, to which she responded: Yes. During an interview on 1/8/26, at 12:20 p.m. the Regional Nurse Consultant (RNC) Employee E1 confirmed that employees should not accept gifts from residents, but that it was not felt to be misappropriation as Resident R88 is alert and oriented. State Agency reminded RNC Employee E1 that the regulation specifically gives an example of misappropriation of a resident who provides monetary assistance to staff, after staff had made resident believe that staff was in a financial crisis. RNC Employee E1 then confirmed that the facility failed to ensure that residents are free from misappropriation of money for one of two residents. 28 Pa. Code: 201.29(a) Resident rights.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that residents' medication regime was free from unnecessary psychotropic (a mind-altering medication) medication for two of five residents (Resident R2 and R9). Findings include: Review of facility Psychotropic Medication Use policy dated 6/18/25, indicated all medications used to treat behaviors must have a clinical indication to be used. As needed, medications shall be limited to 14 days and cannot be renewed unless the attending physician evaluates the resident for the appropriateness of that medication. The physician must document rationale for medication for more than 14 days. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/14/25, indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and wound infection. Review of Resident R2's clinical record revealed physician orders for the following psychotropic medications and failed to have a diagnosis for use of the medication: Sertraline (used to treat depression) 100 mg (milligrams) daily - no diagnosis indicated Seroquel (used to treat mental health disorders) 200 mg daily - no diagnosis indicated. During an interview on 1/8/26, at 9:08 a.m. the Director of Nursing (DON) stated, I've seen medications don't have diagnosis and I've been working on it. During an interview on 1/8/26, at 11:54 a.m. Registered Nurse Employee E13 stated, When we put orders in, we put the diagnosis of the medication in the order. It's been beaten in my head over the years to do that. Review of the clinical record indicated Resident R9 was admitted to the facility on [DATE]. Review of Resident R9's MDS dated [DATE], indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and anxiety. Review of Resident R9's physician orders dated 10/16/25, indicated to administer Ativan (used to treat anxiety) one milligram every two hours as needed (PRN) for anxiety/restlessness. Review of Resident R9's physician order failed to include a 14 day stop date and there was no documented rationale by the physician for the medication to extend past 14 days for Resident R9's Ativan. During an interview on 1/8/26, at 2:00 p.m. the DON confirmed Resident R2's medications did not include a diagnosis for use and the facility failed to make certain that medical records on each resident are complete and accurately documented for one of five residents (Resident R2), and confirmed that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication for one of five residents (Resident R9). 28 Pa. Code 211.2(d)(3) Medical Director. 28 Pa. Code 211.10(a) Resident care policies.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policy, review of personnel files, and staff interview, it was determined that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for one of five personnel files reviewed (Licensed Practical Nurse (LPN) Employee E9). Findings include: Review of facility policy Abuse, Neglect and Exploitation dated 6/18/25, indicated it is the policy of the Facility to undertake background checks of all employees and to retain on file applicable records or current employees regarding such checks. Review of the facility Payroll/Human Resources Coordinator job description indicated an essential function of the position is to ensure that pre-screening of employees is completed (license verification, exclusion checks, background checks, drug screen/physical as required). Maintain complete employee files with accurate and up-to-date information. Review of LPN Employee E9's personnel file revealed a hire date of 9/25/25. Review of the personnel file did not include a completed state criminal background check prior to their date of hire. During an interview on 1/7/26, at 10:31 a.m. Human Resources Employee E2 confirmed that the facility failed to properly screen an employee by failing to conduct a criminal background check prior to the start of employment for one of five personnel files reviewed (LPN Employee E9). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.19(8) Personnel records.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical record, incident reports, reports submitted to the State, and staff interview it was determined that the facility failed to report an incident of neglect for two of five residents (Resident R71, and R88). Findings include: Review of facility Pennsylvania Resident Abuse policy dated 6/18/25, indicated all reports of resident abuse, neglect, misappropriation of resident property are reported immediately to the administrator, Director of nursing, and to the applicable state agency. Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/8/25, indicated diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease (a degenerative brain disease that affects muscle control, among other symptoms), and depression. Review of Resident R71's care plan dated 8/6/24, indicated to monitor the resident frequently within the unit. Review of Resident R71's care plan dated 9/26/24, indicated to observe frequently and place in supervised area when out of bed. Review of Resident R71's progress note dated 12/4/25, at 8:34 p.m. stated Resident was found in the MIU (Memory Impaired Unit) hall sitting in a chair with a bottle of [NAME] Perineal and Skin Cleanser open and appeared that she had drank some of the soap. Poison Control called and verified product is non-toxic and to just monitor. Called and spoke with the on-call provider who advised to just continue to monitor. The resident's family was notified and advised of the incident and explained the providers recommendation along with Poison Control. Review of Nurse Aide (NA), Employee E20's witness statement dated 12/4/25, revealed NA, Employee E20 was exiting another resident's room when Resident R71 was observed running up the hallway with a bottle in hand. The resident then sat on a chair and tipped the bottle back in her mouth. The item was in the resident's closet on the top shelf in a closed container. Resident has previously demonstrated that she is capable of retrieving items. Review of information submitted to the State Agency on 12/4/25, and 12/5/25, failed to include Resident R71's incident of neglect. During an interview on 1/8/25, at 12:37 p.m. the Regional Nurse Consultant, Employee E1 confirmed that the facility failed to report an allegation of neglect for one of five residents (Resident R71). Review of the clinical record revealed that Resident R88 was admitted to the facility on [DATE]. (continued on next page)		

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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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 88's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/12/25, indicated diagnoses of high blood pressure, thyroid disorder, and chronic pain. Review of a written statement dated 12/24/25, revealed that Business Office Manager (BOM) Employee E15 stated the following: As I was reviewing the RFMS (Resident Fund Management Service- banking account information) account for Resident R88 on 12/24/25, I noticed a check issued to Nurse Aide Employee E29 in the amount of \$750 on April 22, 2025. I asked the resident who this person was and why he asked for the check to be issued as it was over the \$500 Medicaid gifting limit. The resident stated, 'That is a nurse aide from here (the facility) who was having a rough time, and I felt bad and wanted to help.' I then informed the resident that he was a very generous person; however, employees are not permitted to receive gifts of any kind from residents. Review of the RFMS report for Resident R88 that was ran on 12/30/25, and included transactions from 1/1/25, through 12/30/25, indicated that two checks were written on 4/22/25, for the amount of \$750. One was for NA Employee E29, and NA Employee E30. The RFMS report also stated that the checks were cashed and cleared on 4/25/25. During an interview on 1/6/25, at 9:54 a.m. Resident R88 stated that he Gave two employees \$750, and they got fired. I feel so bad. During an interview on 1/7/25, at 2:54 p.m. BOM Employee E15 was asked if the resident is able to write his own checks from the RFMS account. BOM Employee E15 stated No. He would have had to get the former BOM to write a check from that account. He (Resident R88) called me and asked me to write him a check for his credit union for \$750. I told him that anything over \$500 gets questioned by Medicaid and advised him to keep it under 500. That's when I checked his account and saw that he had written other checks for \$750 (to NA Employee E29, and E30). BOM Employee E15 was asked if the former BOM should have advised him not to write a check out to employees, to which she responded: Yes. Review of information submitted to the State Agency from 11/24/25 through 1/8/26, failed to include Resident R88's misappropriation of money. During an interview on 1/8/26, at 12:20 p.m. the Regional Nurse Consultant (RNC) Employee E1 confirmed that the facility failed to report misappropriation of money for Resident R88. 28 Pa Code: 201.14 (a)(c) Responsibility of licensee.28 Pa Code: 201.18 (b)(1)(e)(1) Management.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, 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, including bed hold policy for two of four residents sampled with facility-initiated transfers (Residents R1 and R5). Findings include:Review of facility policy Discharge Planning dated 6/18/25, indicated transfers and discharges will meet requirements. The facility will take steps to ensure that the transfer or discharge is documented in the resident's medical record and necessary information is communicated to the receiving health care institution or provider.Review of facility policy Bed Hold Letter dated 6/18/25, indicated it is the policy of the facility to track bed hold days and notify appropriate parties via bed hold letter.Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/12/25, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), arthritis, and cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain).Review of the clinical record indicated Resident R1 was transferred to the hospital on [DATE], and returned to the facility on [DATE].Review of Resident R1'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 bed hold policy, to meet the resident's specific needs at the receiving facility.Review of the clinical record revealed that Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's MDS dated [DATE], indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), heart failure, and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time).Review of the clinical record indicated Resident R5 was transferred to the hospital on [DATE], and returned to the facility on [DATE].Review of Resident R5'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 bed hold policy, to meet the resident's specific needs at the receiving facility.During an interview on 1/9/26, at 9:11 a.m. Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of four residents sampled with facility-initiated transfers (Residents R1 and R5).28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to provide care and treatment as ordered by physician for one of three residents (Residents R71). Findings include: Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE], with diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease (a degenerative brain disease that affects muscle control, among other symptoms), and depression. Review of Resident R71's care plan dated 4/22/25, indicated the resident has Parkinson's disease and to provide drug therapy per order. Review of Resident R71's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/8/25, indicated diagnoses were current. Review of Resident R71's Neurology after visit summary dated 11/19/25, revealed the resident was ordered to increase 20 mg (milligrams) entacapone (medication used primarily to treat symptoms of Parkinson's disease by enhancing effects of Sinemet), 1 tablet, four times a day, take with each of the first four doses of Sinemet (medication used to treat Parkinson's symptoms) in order to extend the benefit of Sinemet and shorten the wearing off dose. Review of Resident R71's progress note dated 11/22/25, revealed the resident was seen by Certified Registered Nurse Practitioner (CRNP), Employee E21 after follow up with neurology appointment. Recommendations to add entacapone 200mg with first four doses of Sinemet. Review of Resident R71's physician order dated 12/1/25, indicated to administer entacapone tablet, 200mg, one tablet, four times a day with first four daily doses of Sinemet. A total of 12 days after it was ordered. During an interview on 1/7/26, at 12:59 p.m. Director of Nursing and Regional Nurse Consultant, Employee E1 confirmed the facility failed to timely administer Resident R71's entacapone to provide care and treatment as ordered by physician for one of three residents (Residents R71). 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive resident-specific plan of care for a resident with limited mobility requiring equipment and assistance to maintain or improve mobility for one of two residents (Resident R10). Review of facility policy Splint Issuance Policy dated 6/18/25, indicated that the patient splint schedule will be communicated to the multidisciplinary team and documented in the care plan. Review of the clinical record revealed that Resident R10 was admitted to the facility on [DATE]. Review of Resident 10's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/12/25, indicated diagnoses of hemiplegia (paralysis on one side of the body), cerebral vascular accident (a loss of blood flow to the brain, which damages brain tissue). Review of Resident R10's clinical record revealed a physician's order dated 9/5/25, to wear resting hand splint to left upper extremity nightly as tolerated at bedtime. Review of Resident R10's care plan failed to include the development of goals and interventions related to Resident R10's resting hand splint usage. During an interview on 1/7/26, at 1:35 p.m. the Director of Nursing confirmed that facility failed to develop and implement a comprehensive resident-specific care plan for Resident R10's resting hand splint. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical record, incident reports, reports submitted to the State, and staff interview it was determined that the facility failed to make certain each resident received adequate supervision which resulted in a resident ingesting a skin cleanser for one of four residents (Resident R71). Findings include: Review of the facility Resident Incident and Accident Report policy dated 6/18/25, indicated an incident is any occurrence that is not consistent with routine care of a particular resident. Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/8/25, indicated diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease (a degenerative brain disease that affects muscle control, among other symptoms), and depression. Review of Resident R71's care plan dated 8/6/24, indicated to monitor the resident frequently within the unit. Review of Resident R71's care plan dated 9/26/24, indicated to observe frequently and place in supervised area when out of bed. Review of Resident R17's progress note dated 12/4/25, at 8:34 p.m. stated Resident was found in the MIU (Memory Impaired Unit) hall sitting in a chair with a bottle of [NAME] Perineal and Skin Cleanser open and appeared that she had drank some of the soap. Poison Control called and verified product is non-toxic and to just monitor. Called and spoke with the on-call provider who advised to just continue to monitor. The resident's family was notified and advised of the incident and explained the providers recommendation along with Poison Control. During an interview on 1/7/25, at 11:02 a.m. the Director of Nursing and Regional Nurse Consultant, Employee E1 confirmed that the facility failed to make certain each resident received adequate supervision to prevent a resident from ingesting a skin cleanser for one of four residents (Resident R71). 28 Pa Code: 201.14 (a)(c) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1)(e)(1) Management.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical record, and staff interview, it was determined that the facility failed to maintain a complete record of pre and post dialysis assessments for one out of three sampled resident records (Resident R11). Findings include: The facility Hemodialysis care policy last reviewed 6/18/25, indicated that communications between the dialysis provider and the facility staff will occur before and after each dialysis appointment. Document the assessment in the dialysis communication tool. Review of Resident R11's admission record indicated she was originally admitted on [DATE] and re-admitted to the facility on [DATE]. Review of Resident R11's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 11/5/25, indicated she had diagnoses that included congestive heart failure (a progressive heart disease affecting pumping action of the heart muscles impacting circulation, swelling and shortness of breath), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and end stage renal disease (gradual loss of kidney function). Review of Resident R11's care plan dated 7/17/23, and updated 11/11/25, indicated to follow up with Dialysis book, chart and record information as noted. Review of Resident R11's 5/10/25, indicated to send to dialysis center on Monday, Wednesday and Fridays. Review of Resident R11's clinical nurse notes dated 9/26/25, indicated that Resident R11 went out of the facility at 9:00 a.m. to dialysis. Review of Resident R11's clinical nurse notes, physician notes and dialysis communication documentation did not include dialysis communications for the month of September 2025. During an interview on 1/9/26, at 9:52 a.m. Medical records/central supply personnel Employee E16 confirmed that the facility failed to maintain a complete record of pre and post dialysis assessments for Resident R11 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(5) Nursing services.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluations at least once every 12 months for two of five nurse aide (NA) personnel records (NA Employees E11 and E19). Findings include: Review of NA Employee E11's personnel record indicated a hire date of 7/1/23. Review of NA Employee E11's personnel record failed to include an annual performance evaluation at least every 12 months as required. Review of NA Employee E19's personnel record indicated a hire date of 7/1/23. Review of NA Employee E19's personnel record failed to include an annual performance evaluation at least every 12 months as required. During an interview on 1/7/26, at 1:45 p.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to complete annual performance evaluations at least once every 12 months for two of five nurse aide personnel records (NA Employee E11 and E19). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.19(2) Personnel records.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure a resident received appropriate behavioral health services to maintain the highest practicable well-being as required (Resident R99). Findings include: The facility Psychotropic Medication Use policy last reviewed 6/18/25, indicated the facility should involve the resident or the resident representative in the discussion of potential non-pharmacologic and medication interventions to address the management of behaviors and the involvement should be documented in the resident's medical record. Review of the clinical record indicated Resident R99 was admitted to the facility on [DATE]. Review of Resident R99's active diagnoses revealed a history of suicidal ideations, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and depression. Review of resident R99's care plan dated 8/19/25, indicated to notify physician of any changes. Review of resident R99's care plan dated 8/21/25, revealed the resident has behavioral symptoms due to anxiety. Interventions included to monitor and report any adverse side effects of medications, assess if anxiety endangers the resident and/or, others and to intervene as necessary, and obtain a psych consult/psychosocial therapy. Resident R99 care plan failed to include suicidal ideations. Review of Resident R99's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/22/25, indicated diagnoses were current. Review of Resident R99's progress note dated 9/4/25, at 10:18 p.m. stated During evening care resident began swinging at the staff and then started to punch himself on his head. No injuries noted at this time and resident has been redirected and placed at the nursing station for monitoring. Review of Resident R99's progress note dated 9/27/25, at 3:21 a.m. stated Resident is becoming increasingly aggressive during late evening and night shifts. He only sleeps sporadically. He yells and screams at the top of his lungs and is unable to be redirected. Any time care is attempted he is punching staff, spitting at them and on them, threatening them with physical violence, and tonight actually threatened to shoot the CNA's (Certified Nurse Aide) and also threatened to choke the CNAs. He is disturbing other residents, sitting in the hall outside their rooms or in their doorways yelling, swearing, and threatening. We cannot safely leave him in bed when he is awake because his fall risk is extremely high and he has already fallen multiple times while he was awake throughout the night and agitated. When staff attempt to move him and his wheelchair back to the nurse's station, he is swinging and grabbing at them while cursing and threatening. He also becomes so agitated that he punches and slaps himself while yelling curse words. This information has been passed on in daily report, but no new orders or treatments have been noted, and staff are now afraid that he is going to hurt himself or them. RN (Registered Nurse) has asked all staff to begin documenting all of these types of behaviors, as we have previously just passed in on as a verbal report. Review of Resident R99's progress note dated 10/13/25, at 10:18 p.m. stated Multiple times throughout the evening resident stating he wants to die, asking staff to kill him, hitting self on his head. Review of Resident R99's clinical record failed to reveal evidence the resident's physician was notified of the resident's behaviors on 9/4/25, 9/27/25, and 10/13/25. Review of Resident R99's physician orders failed to reveal an order for psych services. Review of Resident R99's clinical record revealed the resident had a behavioral health comprehensive diagnostic evaluation on 10/14/25. It was indicated the resident has a history of depression, with history of suicidal ideations, as well as dementia-related behavioral disturbances. During the evaluation the resident denied any active suicidal ideations, nor any intent or plan to harm self. Resident has history of making similar comments in the past. During an interview on 1/6/25, Licensed Practical Nurse (LPN), Employee E3 stated when working on the memory impaired unit, staff must keep an eye out and try to calm down and redirect residents before behaviors occur. If witnessed verbal or physical aggression, separate the resident, notify physician and obtain any (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders. During an interview on 1/8/25, at 9:24 a.m. the Director of Nursing, stated residents with a history of suicidal ideation typically receive a psych consult and social services sees them immediately to ensure no active ideations are present. During an interview on 1/8/25, at 9:35 a.m. Social Service Director, Employee E18 stated if a resident has a history of suicidal ideation, then suicide screen is completed which identifies if they have a plan to harm themselves or others would be completed immediately. Social Service Director, Employee E18 stated psych and the resident's attending physician would be notified. Residents with suicide ideation are care planned with interventions. During an interview on 1/8/25, at 9:47 a.m. Social Service Director, Employee E18 confirmed Resident R99 did not see psych services until 10/14/25. The Social Service Director confirmed the facility failed to address Resident R99's suicide ideations and behaviors timely. During an interview on 1/8/26, at 10:52 a.m. information was disseminated to the Regional [NAME] President of Operations, Employee E17, that the facility failed to ensure one of six residents received appropriate behavioral health services to maintain the highest practicable well-being as required (Resident R99). 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3)(e)(1) Management28 Pa. Code 211.12(c)(d)(3) Nursing services28 Pa. Code 211.16(a) Social services		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical documentation and staff interview it was determined that the facility failed to provide sufficient and timely social services to one of three residents reviewed (Resident R99). Findings include: Review of the clinical record indicated Resident R99 was admitted to the facility on [DATE]. Review of Resident R99's active diagnoses revealed a history of suicidal ideations, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), anxiety, and depression. Review of resident R99's care plan dated 8/21/25, revealed the resident has behavioral symptoms due to anxiety. Interventions included to monitor and report any adverse side effects of medications, assess if anxiety endangers the resident and/or, others and to intervene as necessary, and obtain a psych consult/psychosocial therapy. Resident R99 care plan failed to include suicidal ideations. Review of Resident R99's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/22/25, indicated diagnoses were current. Review of Resident R99's progress note dated 9/4/25, at 10:18 p.m. stated During evening care resident began swinging at the staff and then started to punch himself on his head. No injuries noted at this time and resident has been redirected and placed at the nursing station for monitoring. Review of Resident R99's progress note dated 9/27/25, at 3:21 a.m. stated Resident is becoming increasingly aggressive during late evening and night shifts. He only sleeps sporadically. He yells and screams at the top of his lungs and is unable to be redirected. Any time care is attempted he is punching staff, spitting at them and on them, threatening them with physical violence, and tonight actually threatened to shoot the CNA's (Certified Nurse Aide) and also threatened to choke the CNAs. He is disturbing other residents, sitting in the hall outside their rooms or in their doorways yelling, swearing, and threatening. We cannot safely leave him in bed when he is awake because his fall risk is extremely high and he has already fallen multiple times while he was awake throughout the night and agitated. When staff attempt to move him and his wheelchair back to the nurse's station, he is swinging and grabbing at them while cursing and threatening. He also becomes so agitated that he punches and slaps himself while yelling curse words. This information has been passed on in daily report, but no new orders or treatments have been noted, and staff are now afraid that he is going to hurt himself or them. RN (Registered Nurse) has asked all staff to begin documenting all of these types of behaviors, as we have previously just passed in on as a verbal report. Review of Resident R99's progress note dated 10/13/25, at 10:18 p.m. stated Multiple times throughout the evening resident stating he wants to die, asking staff to kill him, hitting self on his head. Review of Resident R99's clinical record failed to reveal evidence social services was provided for the resident's behaviors on 9/4/25, 9/27/25, and 10/13/25. A further review failed to include evidence the resident's suicidal ideations were addressed. During an interview on 1/8/25, at 9:24 a.m. the Director of Nursing, stated residents with a history of suicidal ideation typically receive a psych consult and social services sees them immediately to ensure no active ideations are present. During an interview on 1/8/25, at 9:35 a.m. Social Service Director, Employee E18 stated I been here about a year. When asked what the process if for a resident who is admitted with a history of suicidal ideation, Social Service Director stated, that hasn't happened thankfully. It was indicated if a resident has a history of suicidal ideation, then a suicide screen is completed which identifies if they have a plan to harm themselves or others would be completed immediately. Social Service Director, Employee E18 stated psych and the resident's attending physician would be notified. During an interview on 1/8/25, at 9:47 a.m. Social Service Director, Employee E18 confirmed Resident R99 did not see psych until 10/14/25. The Social Service Director confirmed the facility failed provide sufficient and timely social services to one of three residents reviewed (Resident R99) 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 211.16(a) Social services. 28 Pa. Code 201.29(a) Resident rights.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records and staff interviews, it was determined that the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one of six residents (Resident R71). Finding include: The facility Medication Regimen Review (MRR) policy last reviewed 6/18/25, indicated that the drug regimen review of each resident is completed at least monthly by the consultant pharmacist and any irregularities are reported. Facility should encourage physician/prescriber or other responsible parties receiving the MRR and the Director of Nursing to act upon recommendation contained in MRR. For those issues that require physician/prescriber intervention, facility should encourage physician/prescriber to either accept and act upon the recommendations contained within the MRR or reject all or some of the recommendations and provide and explanations as to why recommendation was rejected. Review of the clinical record indicated Resident R71 was admitted to the facility on [DATE]. Review of Resident R71's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/8/25, indicated diagnoses of dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease (a degenerative brain disease that affects muscle control, among other symptoms), and depression. Review of Resident R71's progress note dated 12/13/25, revealed the resident was evaluated for dysuria (painful or uncomfortable urination). The physician ordered 200mg (milligrams) phenazopyridine (a medication used to treat symptoms of a urinary tract infection), three times a day for three days. Review of Resident R71's physician order dated 12/13/25, indicated to administer 200mg phenazopyridine, three times a day. No end date was entered. Review of Resident R71's medication regimen reviews (MRR) dated 12/18/25, revealed the resident has received Phenazopyridine for symptomatic relief of dysuria greater than two days. Prolonged use may mask the symptoms of unresolved cystitis and increase the risk of complications. Recommendations indicated to please discontinue Phenazopyridine. A review of Resident R71's clinical record revealed the Phenazopyridine was discontinued on 12/26/25. A total of 11 days since the medication was to be discontinued. During an interview on 1/7/26, at 12:59 p.m. the Director of Nursing and the Regional Nurse Consultant, Employee E1 confirmed that the facility failed to ensure each resident's drug regimen was free from unnecessary drugs for one of six residents (Resident R71). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code 211.5(f) Medical records. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, 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 one of five residents (Resident R2). Findings include: Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/14/25, indicated diagnoses of high blood pressure, bipolar disorder (a mental condition marked by alternating periods of elation and depression), and wound infection. Review of Resident R2's clinical record revealed physician orders for the following medications and failed to have a diagnosis for use of the medication: Tylenol (used to treat pain) 325 mg (milligram) every six hours - no diagnosis indicated Docusate Sodium (used to treat constipation) 100 mg at bedtime - no diagnosis indicated Famotidine (used to treat acid reflux) 20 mg daily - no diagnosis indicated Lasix (used to treat edema) 20 mg every other day - no diagnosis indicated Synthroid (used to treat thyroid disorder) 50 mcg (microgram) daily - no diagnosis indicated Meropenem (antibiotic) 500 mg every eight hours - no diagnosis indicated Milk of Magnesia (used to treat constipation) 400 mg daily as needed - no diagnosis indicated Montelukast (used to treat asthma) 10 mg at bedtime - no diagnosis indicated Omeprazole (used to treat acid reflux) 20 mg daily - no diagnosis indicated Oyster Shell Calcium (vitamin) one tab at bedtime - no diagnosis indicated Potassium Chloride (used for low potassium) 20 [NAME] (milliequivalent) twice daily - no diagnosis indicated Qulipta (used to treat headaches) 60 mg daily - no diagnosis indicated Solifenacin (used to treat overactive bladder) 5 mg daily - no diagnosis indicated During an interview on 1/8/26, at 9:08 a.m. the Director of Nursing (DON) stated, I've seen medications don't have diagnosis and I've been working on it. During an interview on 1/8/26, at 11:54 a.m. Registered Nurse Employee E13 stated, When we put orders in, we put the diagnosis of the medication in the order. It's been beaten in my head over the years to do that. During an interview on 1/8/26, at 2:00 p.m. the DON confirmed Resident R2's medications did not include a diagnosis for use and the facility failed to make certain that medical records on each resident are complete and accurately documented for one of five residents (Resident R2). 28 Pa. Code: 211.5(f) Clinical records.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 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 of the required committee members for two of four quarters (January 2025 through March 2025 and July 2025 through September 2025). Findings include: A review of the QAA Committee meeting sign-in sheets from the period of January 2025 through March 2025, did not reveal that the Medical Director or Infection Preventionist were in attendance. A review of the QAA Committee meeting sign-in sheets from the period of July 2025 through September 2025, did not reveal that the Director of Nursing or Infection Preventionist were in attendance. During an interview on 1/9/25 at 10:33 a.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e)(1)(2)(3)(4) Management.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to provide accurate and timely documentation related to the COVID-19 (a respiratory disease) vaccine for two of five residents (Resident R83, and R95). Findings include: Review of facility policy Resident Vaccination dated 6/18/25, indicated that residents or their responsible party will be asked about prior vaccinations at admission. Prior doses of influenza, pneumococcal, COVID-19, and other vaccines will be documented in the immunization portal in the electronic health record. The Infection Preventionist will track resident immunizations and that vaccines are administered timely. Review of Resident R83's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R83's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/24/25, indicated diagnoses of depression, chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and epilepsy (disorder of the brain characterized by repeated seizures). Resident R83's MDS assessment section C0200 Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact, 8-12: moderately impaired, 0-7: severe impairment. Resident R83's BIMS score was a 11 indicating Resident R83 was moderately impaired. MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. During a review of clinical records indicated that Resident R83 last received a COVID-19 vaccination on 11/27/23. During a review of Resident R83's clinical documentation labeled, Preventive Health Care indicated that on 10/17/25, no consent for vaccine was obtained and resident refused. Resident R83 is cognitively impaired and unable to provide consent and has a guardian that oversees the residents' care and treatment. During a review of Resident R83's clinical record on 1/7/26, at 9:00 a.m. failed to include documentation of an up-to-date Covid-19 booster vaccine was offered and that education was provided to Resident R83's guardian. Review of Resident R95's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R95's MDS dated [DATE], indicated diagnoses of quadriplegia (paralysis of all four limbs), cerebral infarction (necrotic tissue in the brain resulting loss of blood and oxygen to the brain), and vitamin deficiency. MDS Section O- Special treatment, Procedures, and Programs O0350 indicated COVID-19 vaccine was coded a 0- resident not up to date. During a review of clinical records indicated that Resident R95 was last offered a COVID-19 vaccination on 11/14/23. During a review of Resident R95's clinical record on 1/7/26, at 9:05 a.m. failed to include documentation that an up-to-date Covid-19 booster vaccine was offered and that education was provided to Resident R95 this year. During an interview on 1/7/26, at 9:20 a.m. Regional Nurse Consultant Employee E1 stated the facility has no documentation that Resident R83, and R95 were offered a COVID-19 vaccination this year. During an interview on 1/7/26, at 9:30 a.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to provide accurate and timely documentation related to the COVID-19 vaccine for two of five residents (Resident R83, and R95). 28 Pa. Code 211.5(f) Clinical records		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility policy, personnel files and staff interview it was determined that the facility failed to conduct the minimum 12 hours of nurse aide (NA) training per year for one of five NA personnel records (NA Employee E11). Findings include: Review of NA Employee E11's personnel record indicated a hire date of 7/1/23. Review of NA Employee E11's personnel record revealed 4.67 hours of in-service education from 1/1/25 through 12/31/25. During an interview on 1/7/26, at 11:31 a.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to conduct the minimum 12 hours of nurse aide training per year for one of five NA personnel records (NA Employee E11). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.20(a) Staff development.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and staff interviews, it was determined that the facility failed to ensure that current and accurate nurse staffing information was available at the beginning of each shift. Findings include: An observation on 1/8/26, at 1:12 p.m. revealed the nurse staffing information was posted near the facility's main entrance and was dated 1/3/26. During the observation, the nurse staffing information had the incorrect date and resident census, and the staffing hours did not accurately reflect the current total number of hours worked for licensed and unlicensed nursing staff directly responsible for nursing care per shift. During an interview on 1/8/26, at 1:22 p.m. Regional Nurse Consultant Employee E1 confirmed that the facility failed to post the required current facility information for staffing hours and the census for 1/8/26. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b) Management.		