

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
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NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402	STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
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F 0000	INITIAL COMMENT	F 0000		
F 0578	<p>Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey, and an Abbreviated Complaint Survey completed on December 5, 2024, it was determined that Kinzua Nursing and Rehab was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.</p>	F 0578		
SS=E				

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0578 SS=E	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	1. Resident 36 and Resident 4 responsible parties were notified and reviewed Advance directive option. Physician Orders for Life-Sustaining Treatment (POLST) were completed for both residents and physician and families notified. 2. Current resident records were reviewed to ensure that current residents have a code status and a current POLST of their wishes for healthcare 3. Director of Nursing or designee will provide education to licensed nurses and the social worker on the advance directive policy and the completion of advanced directives on admission. 4. Director of Nursing will audit admissions to ensure that current residents have a code status including a current POLST. Audits will be completed 3 times weekly for 2 weeks then Monthly until compliance is met. Audits will be reviewed at Quality Assurance meetings monthly until compliance is met.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/23/2024

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F 0578 SS=E	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

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F 0578 SS=E	Continued from page 3 Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to comprehensively address the formulation of advance directives (legal instructions regarding your preferences for medical care if you are unable to make decisions for yourself-to include information provided oral and/or written instructions about future medical care in the event of becoming unable to express medical wishes) for two of 24 residents reviewed (Residents R4 and R36). Findings include: A facility policy entitled, "Advanced Directives" dated 12/02/24, indicated the following: -upon admission the resident and/or representative will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an Advanced Directive if he or she chooses to do so. - prior to or upon admission the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal	F 0578		

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F 0578 SS=E	Continued from page 4 representative about the existence of any written advanced directives. - the Social Services (or designee) will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. - the resident's attending physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes to clarify and adhere to the resident's wishes. Resident R36's clinical record revealed an admission date of 1/22/18, with diagnoses that included pervasive developmental disorder (developmental delay that affects social and communication skills), unspecified psychosis (diagnosis used when there isn't enough information to diagnose a specific psychotic disorder), difficulty speaking, and dementia with agitation. The clinical record also included a physician's order dated 10/28/19, that identified Resident R36 as a "Full Code" (medical directive that indicates that a patient wants to receive cardiopulmonary resuscitation [CPR] and all	F 0578		

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F 0578 SS=E	<p>Continued from page 5</p> <p>other medical treatment to save their life if their heart and lungs stop working).</p> <p>Further review of Resident R36's clinical record revealed that the facility failed to comprehensively address the formulation of advance directives instructions regarding his/her preferences for medical care if he/she was unable to make decisions.</p> <p>During an interview on 12/03/24, at 11:31 a.m. Registered Nurse (RN) Employee E1 confirmed there was no evidence of a POLST (Physician Orders for Life Sustaining Treatment- document that provides a structure for conversations about end-of-life issues and patient preferences for treatment as the end of life nears) or an advance directive in Resident R36's clinical record.</p> <p>During interviews on 12/03/24, at 11:35 a.m. RN Employee E1, Licensed Practical Nurse (LPN) Employee E4, and LPN Employee E3 confirmed that they would prioritize following the instructions on a POLST or advance directive, and that the</p>	F 0578		

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F 0578 SS=E	Continued from page 6 POLST should be in the resident's clinical record. During an interview on 12/04/24, at 8:45 a.m. RN Employee E5 confirmed there was no evidence of a POLST or advance directive in Resident R36's clinical record, no evidence that advance directives were reviewed and a signature obtained from the resident or responsible party, and also confirmed that each clinical record should have one. Review of Resident R4's clinical record revealed an admission date of 10/19/18, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), hyperlipidemia (high cholesterol), and chronic obstructive pulmonary disease (condition when your lungs do not have adequate air flow). Review of Resident R4's clinical record revealed an order for Do Not Resuscitate (DNR- medical directive that indicates that a patient does not want to receive CPR. Further review of Resident R4's	F 0578		

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F 0578 SS=E	Continued from page 7 clinical record revealed other than an order for a DNR, there was no evidence Resident R4 was provided written information on advance directives or assisted with the opportunity to formulate advance directives regarding treatment in the event he/she could not make decisions regarding her health care. During an interview on 12/3/24, at 10:46 a.m. the Director of Nursing confirmed that the facility did not have evidence of written information on advance directives for Resident R4. He/she also confirmed that Resident R4 should have written information on advance directives in his/her clinical record. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i) Medical records	F 0578		

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F 0578 SS=E	Continued from page 8 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0578		
F 0584 SS=D		F 0584		

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F 0584 SS=D	Continued from page 9 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Room 520 was picked up at the time of notification and was cleaned the same day. R37's wheel chair was cleaned the same day. 2. Nursing Home Administrator or designee will educate all housekeeping staff to ensure the policy and procedure is followed when cleaning resident rooms and wheelchairs. 3. Nursing Home Administrator or designee will educate all housekeeping staff on "Daily Resident/Patient Room Cleaning" and "Quality of Life-Homelike Environment" staff will date and sign the task checklist daily. 4. The Administrator or designee will audit 5 resident rooms and wheelchairs for cleanliness and signed daily task checklists 3 x week x 2 weeks, 2 x week x 2 weeks and weekly x 2 weeks. Findings will be discussed at our monthly Quality Assurance meeting and changes will be made if necessary.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0584 SS=D	Continued from page 10 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 11 Based on observations, review of facility policies and documents, and staff, resident, and visitor interviews, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean environment in one resident room (520) and clean equipment for one resident (Resident R37). Findings include: A facility policy entitled "Quality of Life-Homelike Environment" dated 12/02/24, indicated facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting and include a clean, sanitary, and orderly environment. A facility document entitled "Daily Resident/Patient Room Cleaning" indicated that resident room floors would be dust mopped, all trash and debris will be swept to the door and picked up with a dustpan. Observation on 12/02/24, at 12:09 p.m. of Room	F 0584		

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F 0584 SS=D	Continued from page 12 520 revealed an open bag of cheese curls, two full 20-ounce plastic bottles of Diet Coke and one empty 20-ounce plastic bottle of Diet Coke on the floor on the right side of the bed between the bed frame and nightstand. Observation on 12/03/24, at 1:13 p.m. of Room 520 revealed an open bag of cheese curls, one empty 20-ounce plastic bottle of Diet Coke, and an open box of tissues box on the floor on the right side of the bed between the bed frame and nightstand. Observation on 12/03/24, at 2:22 p.m. of Room 520 revealed one empty 20-ounce plastic bottle of Diet Coke, and an open box of tissues box on the floor on the right side of the bed between the bed frame and nightstand, and the open bag of cheese curls on the resident's tray table. At that time, a visitor for Room 520 confirmed he/she picked up the open bag of cheese curls upon entering the room. Observations on 12/03/24, at 2:22 p.m. with the	F 0584		

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F 0584 SS=D	<p>Continued from page 13</p> <p>Nursing Home Administrator (NHA) he/she confirmed that the food items and tissues should not have been on the floor. The NHA removed the opened bag of cheese curls from the resident room.</p> <p>Review of Resident R37's clinical record revealed an admission date of 2/1/24, with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), hyperlipidemia (high cholesterol) and hypertension (high blood pressure).</p> <p>Observations on 12/2/24, at 2:47 p.m. revealed Resident R37 sitting in his/her wheelchair on a cushion. Observations of the cushion revealed what appeared to be food stuck to the cushion. Further observations of Resident R37's wheelchair revealed what resembled food laying on the frame of the wheelchair.</p> <p>Observations on 12/3/24, at 10:20 a.m. revealed Resident R37's wheelchair sitting next to his/her</p>	F 0584		

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F 0584 SS=D	Continued from page 14 bed. The food like substance remained on the wheelchair cushion. Further observations of Resident R37's wheelchair revealed that the food like substance remained laying on the frame of the wheelchair. Observations on 12/4/24, at 11:45 a.m. revealed Resident R37 sitting in his/her wheelchair with the food like substance remaining on the cushion. Further observations of Resident R37's wheelchair revealed that the food like substance remained laying on the frame of the wheelchair. During an interview on 12/4/24, at 11:48 a.m. with the NHA, he/she confirmed that there was food like substance on Resident R37's wheelchair cushion and on the frame of the wheelchair frame. He/she also confirmed that the wheelchair and cushion should be clean. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management	F 0584		

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F 0584 SS=D	Continued from page 15 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 207.2(a) Administrator's responsibility	F 0584		
F 0625 SS=A	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 0625	I hereby acknowledge the CMS 2567-A, issued to Kinzua Nursing and Rehab for the survey ending 12/5/2024, AND attest that all deficiencies listed on the form will be corrected in a timely manner.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0625 SS=A	Continued from page 16 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 0625		

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F 0625 SS=A	Continued from page 17 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold (explanation of how long a bed can be held during a leave of absence and the cost per day) upon or within twenty-four hours of transfer for two of seven residents reviewed for hospitalizations (Residents R52 and R72). Findings include: A facility policy entitled "Bed-Hold Notification - Pennsylvania" dated 12/02/24, indicated that in the event it become necessary for the resident to be taken to the hospital the resident and/or their responsible party will be offered the choice to hold the resident's bed. Resident R52's clinical record revealed an admission date of 4/17/24, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting	F 0625		

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F 0625 SS=A	<p>Continued from page 18</p> <p>in difficulty breathing), dementia (loss of cognitive functioning affecting a persons memory and behaviors), and high blood pressure.</p> <p>Departmental notes indicated that Resident R52 was transferred to the hospital on 12/02/24. The clinical record lacked evidence indicating that Resident R52 and/or their representative was provided with a copy of the facility bed-hold policy.</p> <p>Resident R72' clinical record revealed an admission date of 3/12/24, with diagnoses that included dementia, prostate cancer, and high blood pressure.</p> <p>Departmental notes indicated that Resident R72 was transferred to the hospital on 10/03/24. The clinical record lacked evidence indicating that Resident R72 and/or their representative was provided with a copy of the facility bed-hold policy.</p> <p>During an interview on 12/04/24, at 12:46 p.m. Regional Nurse Consultant confirmed that there was</p>	F 0625		

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F 0625 SS=A	Continued from page 19 no evidence that Resident R52 and/or their representative received written notice of the facility bed-hold policy upon or within twenty-four hours of transfer. During an interview on 12/05/24, at 8:21 a.m. Regional Nurse Consultant confirmed that there was no evidence that Resident R72 and/or their representative received written notice of the facility bed-hold policy upon or within twenty-four hours of transfer. 28 Pa. Code 201.18(e)(1) Management	F 0625		
F 0684 SS=E		F 0684		

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F 0684 SS=E	Continued from page 20 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	<ol style="list-style-type: none"> Resident R69 was addressed immediately to ensure sling and collar were on and Dr. notified. R17 order for the telehealth visit was discontinued as per physician. R65 order for boot was discontinued after consultation with therapy as it was deemed it was no longer necessary for the patient. Director of Nursing or designee will audit 5 residents weekly for three weeks to review physician orders are being followed. Redline process, review of all new orders, discontinued orders, labs and appointments, will be put into place for third shift supervisor to review all new orders and discontinued orders daily. Director of Nursing or designee will educate Licensed staff and certified nursing aids on Verbal physician care orders and physician orders. Reviewed with staff on where to see orders/tasks for residents and to ensure those measures are in place for each resident. Audits of 5 residents per week x 3 weeks on care orders and 	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0684 SS=E	Continued from page 21	F 0684	appointments to ensure they are active and in place. Audits will be completed 5 residents per week x 3 weeks and monthly until cleared by quality assurance meeting.		

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F 0684 SS=E	<p>Continued from page 22</p> <p>Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure physician's orders were followed for three of 24 residents reviewed (Residents R17, Resident R65, and Resident R69).</p> <p>Findings include:</p> <p>Resident R69's clinical record revealed an admission date of 10/24/24, with diagnoses that included stroke, breast cancer, and high blood pressure.</p> <p>Resident R69's clinical record revealed a physician's order dated 10/31/24, for a left arm sling to be worn at all times except for hygiene purposes. There was also an order dated 11/20/24, for a soft cervical (neck) collar to be applied when out of bed, in wheelchair for cervical support and improved posture, may remove for eating.</p> <p>Observation of Resident R69 on 12/03/24, at approximately 10:47 a.m. revealed he/she was sitting in a wheelchair without a left arm sling or soft</p>	F 0684		

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F 0684 SS=E	Continued from page 23 cervical collar. Observation of Resident R69 on 12/04/24, at approximately 9:20 a.m. revealed he/she was sitting in a wheelchair without a left arm sling or soft cervical collar. During an interview on 12/04/24, at 9:25 a.m. the Regional Nurse Consultant confirmed that Resident R69 was not utilizing a left arm sling or soft cervical collar as physician ordered. Resident R17's clinical record revealed an admission date of 6/07/24, with diagnoses that included hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones), and hyperlipidemia (high cholesterol). During an interview on 12/02/24, at 2:00 p.m. Resident R17 revealed that he/she was to have a dermatology appointment for his/her skin rash. He/she stated that the appointment was canceled	F 0684		

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F 0684 SS=E	<p>Continued from page 24</p> <p>due to COVID and he/she has yet to have an appointment with dermatology.</p> <p>Resident R17's clinical record revealed a physician's order dated 9/05/24, to schedule Telederm (a dermatology evaluation done remotely) appointment. Resident R17's clinical record lacked evidence that the appointment was scheduled or that Resident R17 has had a dermatology appointment.</p> <p>During an interview on 12/04/24, at 11:52 a.m. the Director of Nursing (DON) confirmed that the Telederm appointment was never scheduled. He/she also confirmed that the appointment should have been scheduled per physician orders.</p> <p>Resident R65's clinical record revealed an admission date of 12/27/23, with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), and hypertension (high blood pressure).</p>	F 0684		

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F 0684 SS=E	Continued from page 25 Resident R65's physician orders revealed, an order dated 5/20/24, for contracture boot application to right foot/ankle to be worn at all times except for general hygiene and regular skin checks. Resident R65's care plan revealed a care plan focus of ADL (Activities of Daily Living) Self Care: with an intervention of use assistive/adaptive equipment: contracture boot to right ankle/foot dated 5/20/24. Observation made on 12/02/24, at 3:10 p.m. revealed Resident R65 sitting in his/her wheelchair without a boot to his/her right foot/ankle. Observation on 12/02/24, at 3:22 p.m. revealed Resident R65 sitting in his/her wheelchair without a boot on his/her right foot/ankle. Observation on 12/02/24, at 4:00 p.m. revealed Resident R65 sitting in his/her wheelchair without a boot to his/her right foot/ankle. Observation on 12/03/24, at 11:00 a.m. revealed Resident R65 lying in his/her bed without a boot to his/her right foot/ankle. Observation on 12/04/24, at 10:32 a.m. revealed Resident R65 lying in his/her bed without a boot to	F 0684		

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F 0684 SS=E	Continued from page 26 his/her right foot/ankle. During observations and interview on 12/04/24, at 11:59 a.m. with the DON, he/she confirmed that Resident R65 did not have a boot on his/her right foot/ankle. He/she also confirmed that Resident R65 should have a boot on his/her right ankle as ordered by the physician. 28 Pa. Code 211.5(f)(i) Clinical records 28 Pa. Code 211.12 (d)(1)(5) Nursing Services	F 0684		
F 0688 SS=E		F 0688		

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F 0688 SS=E	Continued from page 27 483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 0688	1. Resident #65 had therapy eval completed to ensure that resident required hand splint. Physician and family were update with recommendations. 2. Current resident with Hand splints were reviewed to ensure that orders were current and equipment available and staff were applying the splint. 3. Director of Nursing or designee will educate Licensed staff and certified nurse aides on splints/adaptive equipment. Reviewed with staff on where to see orders/tasks for residents with splints/adaptive equipment. 4. Audits of residents with hand splints will be completed to ensure that residents have the splints on as per ordered and proper documentation supporting the wearing of those splints. Audits will be completed 3x weekly for 2 weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meetings monthly until compliance is met.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0688 SS=E	Continued from page 28 Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that a resident with limited range of motion received treatment and services to prevent further decrease in range of motion for one of two residents reviewed for range of motion (Resident R65). Findings include: Review of Resident R65's clinical record revealed an admission date of 12/27/23, with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat), and Hypertension (high blood pressure). Review of Resident R65's Occupational Therapy Discharge Summary dated 1/24/24, revealed a long term goal that include: "patient will safely wear a	F 0688		

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F 0688 SS=E	Continued from page 29 resting hand splint on left hand for up to eight hours with minimal signs or symptoms of redness, swelling, discomfort or pain." Observation made on 12/02/24, at 3:10 p.m. revealed Resident R65 sitting in his/her wheelchair with hand splint lying on bedside stand and no hand splint to his/her left hand. Observation on 12/02/24, at 3:22 p.m. revealed Resident R65 sitting in his/her wheelchair with hand splint lying on bedside stand and no hand splint to his/her left hand. Observation on 12/02/24, at 4:00 p.m. revealed Resident R65 sitting in his/her wheelchair with hand splint lying on bedside stand and no hand splint to his/her left hand. Observation on 12/03/24, at 11:00 a.m. revealed Resident R65 lying in his/her bed with hand splint lying on bedside stand and no hand splint to his/her left hand. Observation on 12/04/24, at 10:32 a.m. revealed Resident R65 lying in his/her bed with no resting hand splint to his/her left hand. During all above observations there was a sign on the wall in Resident R65's room at the head of bed	F 0688		

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F 0688 SS=E	Continued from page 30 that read "Resting hand splint on at all times during day (wake up to HS) (hour of sleep)." During an interview on 12/03/24, at 11:00 a.m. with the Resident R65 and his/her significant other revealed that Resident R65 should have a hand splint applied to his/her left hand during the day. Resident R65 stated that he/she cannot remember the last time his/her hand splint was applied to his/her left hand. Resident R65's significant other stated that the hand splint was laying on Resident R65's nightstand in his/her room and that there was a sign above the head of Resident R65's bed that reminded staff to apply the hand splint. Significant other stated that Resident R65 has had three different room changes and the sign above Resident R65's bed has been placed above Resident R65's bed in all three rooms. Resident R65 and significant other further expressed that Resident R65's fingers push into his/her hand which causes his/her fingernails to push into his/her skin. Resident R65 stated that he/she wants the resting hand splint to be applied. Resident R65 stated that staff never applies	F 0688		

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F 0688 SS=E	Continued from page 31 the hand splint. During an interview with the Director of Rehab (DOR) on 12/05/24, at 8:57 a.m. he/she revealed that when Resident R65 discharged from therapy services he/she was discharged with a resting hand splint to be applied to Resident R65's left hand for eight hours a day. DOR expressed that the process to continue resident goals after a resident is discharged from therapy is that the resident's long term goals are e-mailed to the Director of Nursing (DON) and the DON inputs the goals into the plan of care for the nursing staff. During observations and interview on 12/04/24, at 11:59 a.m. with the DON, he/she confirmed that Resident R65 did not have a hand splint to his/her left hand and a sign was posted at the head of Resident R65's bed for the hand splint to be applied. The DON also confirmed that the hand splint should be applied every day. 28 Pa. Code 201.18(b)(1) Management	F 0688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
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F 0688 SS=E	Continued from page 32 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0688		
F 0690 SS=E		F 0690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
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F 0690 SS=E	Continued from page 33 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 0690	1. Resident #1 suprapubic catheter was last changed on 10/11/2024. Physician was notified that suprapubic catheter was not changed as per order in April, June, and November. No ill effects occurred due to catheter not being changed. Resident #5 foley was immediately put in a basin so it didn't touch the floor. Resident #11 foley was repositioned to ensure it was positioned below the bladder. 2. Current residents with foley/suprapubic catheters were reviewed to ensure that catheters were being changed as per physician orders, that catheter bags were not on the floor, and to ensure that catheter bags were positioned below the bladder to prevent back flow of urine 3. Director of Nursing or designee will provide education to Licensed staff and Certified Nurse Aides on Catheter care policy and the Supra pubic catheter policy. She will educate on following physician orders for catheter changes, ensuring that the catheter bags are	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0690 SS=E	Continued from page 34 This REQUIREMENT is not met as evidenced by:	F 0690	not on the floor, and that the staff must position the catheter below the bladder to prevent back flow of urine. 4. The Director of Nursing or designee will audit to ensure that all catheters are changed per physician order, the foley is not on the floor, and that the catheter bag is positioned appropriately. Audits will be completed on all catheters 3x weekly for 2weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meetings monthly until compliance is met.	

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F 0690 SS=E	Continued from page 35 Based on review of facility policies and clinical records, observations, and staff interviews, it was determined that the facility failed to provide appropriate care regarding a urinary catheter (a tube inserted into the bladder to drain urine into a bag) for three of five residents reviewed for catheters (Residents R1, R5, and R11) Findings include: A facility policy entitled "Suprapubic Catheter Replacement" dated 12/02/24, indicated that the date and time of the procedure, name of individual performing the procedure, and signature and title of the person completing the procedure should be recorded in the resident's medical record. A facility policy entitled "Catheter Care, Urinary" dated 12/02/24, indicated "Maintain Unobstructed Urine Flow 3. The urinary drainage bag must be held or positioned lower than the bladder at all times ... and Infection Control 2. b. Be sure the catheter tubing and drainage bag are kept off the floor."	F 0690		

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F 0690 SS=E	Continued from page 36 Resident R1's clinical record revealed an admission date of 12/22/22, with diagnoses that included obstructive and reflux uropathy (occurs when the urine flow is blocked due to an obstruction and the urine flows backwards from the bladder into the kidneys), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R1's clinical record revealed a physician's order dated 3/16/24, and again on 7/12/24, that indicated "Suprapubic Catheter change monthly every day shift every 30 days" and "Suprapubic Catheter bag change monthly every day shift every 30 days." Review of the Treatment Administration Record (TAR) and clinical record progress notes lacked evidence that Resident R1's Suprapubic Catheter and Suprapubic Catheter Bag was changed during the month of April 2024 , June 2024, and November 2024 as ordered by the physician.	F 0690		

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F 0690 SS=E	<p>Continued from page 37</p> <p>During an interview on 12/04/24, at 1:36 p.m. the Regional Nurse Consultant confirmed that the facility lacked evidence that Resident R1's Suprapubic Catheter and Bag were changed in April, June, and November 2024 per physician orders.</p> <p>Resident R5's clinical record revealed an admission date of 10/19/07, with diagnoses that included obstructive and reflux uropathy, and dementia (a disease that affects short term memory and the ability to think logically).</p> <p>Resident R5's physician orders revealed an order dated 11/30/24, for a foley catheter.</p> <p>Observation on 12/02/24, at 3:08 p.m. revealed Resident R5's urinary drainage bag lying on the floor without a cover in place and the drainage valve (the part of the urinary bag that opens to empty urine from the bag) touching the floor. Observation on 12/02/24, at 3:45 p.m. revealed Resident R5's</p>	F 0690		

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F 0690 SS=E	Continued from page 38 urinary drainage bag remained lying on the floor without a cover in place and the drainage valve touching the floor. Observation on 12/02/24, at 4:13 p.m. with the Registered Nurse Assessment Coordinator (RNAC) revealed Resident R5's urinary drainage bag remained lying on the floor without a cover in place and the drainage valve touching the floor. During an interview on 12/02/24, at 4:13 p.m. the RNAC confirmed that the urinary drainage bag was lying on the floor with the drainage valve touching the floor and without a cover on the urinary drainage bag. He/she also confirmed that the urinary drainage bag should not be on the floor and the urinary drainage bag should have a cover on it. Resident R11's clinical record revealed an admission date of 10/30/23, with diagnoses that included neurogenic bladder dysfunction (urinary bladder problem due to disease or injury of the nervous system involved in the control of urine), and	F 0690		

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F 0690 SS=E	Continued from page 39 hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Resident R11's physician orders revealed an order dated 10/16/24, for foley catheter. Observation on 12/02/24, at 3:11 p.m. revealed Resident R11 was sitting in his/her wheelchair with his/her foley catheter drainage bag hanging off of his/her wheelchair armrest and was higher than their bladder. Observation made on 12/02/24, at 3:47 p.m. revealed Resident R11 remained sitting in his/her wheelchair with his/her foley catheter hanging off of his/her wheelchair armrest and was higher than their bladder. Observation on 12/02/24, at 4:16 p.m. with the RNAC revealed Resident R11 was sitting in his/her wheelchair with his/her foley catheter drainage bag hanging off of his/her wheelchair armrest and was higher than their bladder. During an interview on 12/02/24, at 4:16 p.m. the RNAC confirmed that Resident R11's foley catheter	F 0690		

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F 0690 SS=E	Continued from page 40 was hanging off of his/her wheelchair arm rest above Resident R11's bladder. He/she also confirmed that Resident R11's foley catheter should not be placed above his/her bladder. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing Services	F 0690		
F 0695 SS=D		F 0695		

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F 0695 SS=D	Continued from page 41 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	1. Obtained an order for oxygen for resident #26. Oxygen at 2 liter as needed. Responsible party was notified of order. 2. Current residents that are using Oxygen were reviewed to determine they had orders for oxygen therapy in electronic medical record. 3. Director of Nursing or designee educated License staff on the respiratory policy. Nurses educated that residents must have an order for oxygen therapy. 4. Director of Nursing or designee will audit all residents to ensure that residents using oxygen therapy have orders for oxygen in electronic medical record. Audits will be completed 3 x weekly for 2 weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meeting monthly until compliance is met.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/23/2024

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F 0695 SS=D	Continued from page 42 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to obtain a physician's order for the provision of oxygen therapy for one of one residents reviewed for respiratory services (Resident R26). Findings include: A facility policy entitled "Oxygen Administration" dated 12/02/24, indicated to verify that there is a physician's order for oxygen administration. Resident R26's clinical record revealed an admission date of 11/06/24, with diagnoses that included chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), dementia (loss of cognitive functioning affecting a persons memory and behaviors), and high blood pressure. Observations on 12/02/24, at 1:45 p.m., 12/03/24, at 11:16 a.m., and 12/03/24, at 12:08 p.m. revealed	F 0695		

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F 0695 SS=D	<p>Continued from page 43</p> <p>Resident R26 wearing an oxygen nasal cannula (a thin tube with two prongs that fits into the resident's nostrils to deliver oxygen) connected to an oxygen concentrator delivering 2 liters per minute.</p> <p>Resident R26's clinical records under "Oxygen sats summary" revealed he/she utilized oxygen on 11/15/24, 11/16/24, 11/29/24, 12/01/24, 12/02/24, and 12/03/24. Clinical record progress notes revealed he/she utilized oxygen on 11/15/24, 11/16/24, 11/17/24, 11/25/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24, 11/30/24, 12/01/24, 12/02/24, and 12/03/24.</p> <p>Resident R26's clinical record lacked evidence of a physician's order for the use of oxygen therapy.</p> <p>During an interview on 12/03/24, at 12:25 p.m. Licensed Practical Nurse Employee E4 confirmed that Resident R26 was being administered oxygen therapy and their clinical record lacked a physician's order for oxygen therapy.</p>	F 0695		

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F 0695 SS=D	Continued from page 44 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0695		
F 0761 SS=E		F 0761		

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F 0761 SS=E	Continued from page 45 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Medication carts were immediately audited to ensure that any multidose vials of insulin, insulin pens, or Tuberculin solutions were dated with open date and that they had not expired since open per manufacturer guidelines. Director of nursing or designee will educate licensed staff on medication storage policy and insulin policy to ensure that staff understands they have to date multidose insulin vials, insulin pens and Tuberculin solutions when opened and they have to follow manufacturer guidelines of when it expires and not to be used after that date. Director of Nursing or designee will audit all medication carts to ensure that insulin vials, insulin pens, and TB solution is dated with an open date and not used beyond expire date. Audits will be completed on 1 cart a day 3x weekly for 2 weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meetings monthly until compliance is met.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0761 SS=E	Continued from page 46 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to label multi-dose containers of insulin (medication to treat elevated blood sugar levels) with the date they were opened and discard an opened multi-dose vial of insulin in a timely manner in two of three medication carts (Gold and Red Units) and discard an opened multi-dose vial of Tuberculin solution (solution used to test for the disease tuberculosis) in one of three medication storage rooms (Red Unit). Findings include: A facility policy entitled, "Insulin Administration" dated 12/02/24, indicated that staff are to check the expiration date, if drawing from an opened multi-dose vial; if opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). A facility policy entitled, "Storage of Medications"	F 0761		

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F 0761 SS=E	Continued from page 47 dated 12/02/24, indicated when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated; the nurse shall place a "date opened" sticker on the medication and enter the date opened and new date of expiration; the expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. Observation on 12/03/24, at 8:57 a.m. of Gold Unit medication cart revealed opened multidose insulin pens for Residents R125, R8, and a multidose vial of insulin for R46 lacking an "opened/use-by" date, and an opened multidose vial of insulin for Resident R62 dated as "opened" on 10/29/24, (expired five days). During an interview at that time, Licensed Practical Nurse (LPN) Employee E3 and Registered Nurse Employee E1 confirmed that the opened undated multidose insulin pens and vial should be labeled with the "opened" date to determine the discard	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
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F 0761 SS=E	<p>Continued from page 48</p> <p>date, and that the opened multidose vial of insulin dated 10/29/24, was expired and should have been discarded.</p> <p>Observation on 12/03/24, at 9:05 a.m. of Red Unit medication cart revealed one opened multidose insulin pen for Resident R27, two opened multidose insulin pens for Resident R10 and R227 lacking an "opened/use-by" date.</p> <p>Observation on 12/03/24, at 9:11 a.m. of Red Unit medication room revealed one opened multidose vial of Tuberculin solution dated "opened" 10/29/24, and labeled to discard in 28 days (seven days expired).</p> <p>During an interview at that time, LPN Employee E2 confirmed that the opened undated multidose insulin pens should be labeled with the "opened" date to determine the discard date, and that the opened multidose vial of Tuberculin solution was expired and should have been discarded.</p> <p>28. Pa. Code 201.18(b)(1) Management</p>	F 0761		

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STATE LICENSE NUMBER: 071402				
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F 0761 SS=E	Continued from page 49 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 211.10(c) Resident care policies	F 0761		
F 0812 SS=E		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
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F 0812 SS=E	Continued from page 50 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. All items found without dates were immediately disposed of. All other pantries/refrigerators were checked for undated items as well as non-dietary items. The heating unit vents were inspected and cleaned the same day. The food disposal under the sink was cleaned the same day. The pantry refrigerator was cleaned of all items that were not labeled and dated. All refrigerators were temped and new temperature logs were put in place. 2. All refrigerators have been checked for temperature logs as well as proper labeling. 3. Nursing Home Administrator or designee will educate whole house on Food Labeling and Dating, Foods Brought by Family/Visitors, and Cleaning and Disinfection of Environmental Surfaces. Education also includes that the dietary manager or designee will temp and log all refrigerator temps daily. 4. Nursing Home Administrator or designee will audit to ensure the heater vents and disposal to ensure clean as well as all refrigerators, in	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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F 0812 SS=E	Continued from page 51	F 0812	the kitchen and the pantries, to ensure food is labeled including date. These will also be audited to ensure no non-dietary items are in the refrigerators. Refrigerator temperature logs will also be audited. The kitchen will be audited to ensure all unrefrigerated items are labeled and dated as well. These audits will be performed 1 refrigerator and the kitchen a day 3 times a week for 2 weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meetings monthly until compliance is met.	

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F 0812 SS=E	Continued from page 52 Based on review of facility policies, observations, and staff interview, it was determined that the facility failed to maintain sanitary operations and standards for food safety in the main kitchen and in one pantry reviewed (Gold Pantry). Findings include: Review of facility policy entitled "Food Receiving and Storage" dated 12/02/24, indicated that "Dry food that are stored in bins are removed from original packaging, labeled and dated ("use by" date)." "Food and snacks kept on the nursing units. 1. All food items to be kept at or below 41 F [Fahrenheit] are placed in the refrigerator ... and labeled with a use by date. 3. Refrigerators ... are monitored for temperature according to state specific guidelines." Additional document entitled "Food Storage Guide" revealed that bakery items including, muffins/pastries/donuts-once opened expires in one week and prepared foods/leftover items, once opened expires in 3 days.	F 0812		

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F 0812 SS=E	Continued from page 53 Review of facility policy entitled "Food Brought by Family/Visitors" dated 12/02/24, revealed that 'food brought in by family/visitors that is left with resident to consume later will be labeled ...perishable foods must be stored in re-sealable containers ... containers will be labeled with resident's name, the item and the use by date...the facility staff will discard perishable foods on or before the use by date." Review of Monthly Sanitation Audit document revealed that vents were to be inspected to be secure, clean and free from dust and drains were to be inspected to be clean and working properly. Observation of the main kitchen on 12/02/24, at 11:35 a.m. with the Dietary Manager revealed a metal container with cake-like squares in individual baggies and the baggies lacked a label and date. Observations of two heating units attached to the kitchen ceiling at each end of the food preparation areas revealed the vents on each of the heating units	F 0812		

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F 0812 SS=E	<p>Continued from page 54</p> <p>had a thick layer of a gray fuzzy substance. Observation in the dishwashing area revealed a food disposal attached under the sink with a thick layer of a dry brown substance.</p> <p>During an interview with the Dietary Manager on 12/02/24, at 11:45 a.m. he/she confirmed the cake-like item's were not labeled or dated, he/she confirmed that the heater vents over the food preparation area had a thick layer of a gray fuzzy substance, and the food disposal under the sink had a thick layer of a dry brown substance. He/she also confirmed that the cake-like substance should be dated and labeled, and the heater vents and the food disposal should be clean.</p> <p>Observations on 12/02/24, at 11:46 a.m. revealed a refrigerator in the pantry used for residents contained food on a paper plate covered with foil with no date; a paper plate in a ziplock bag with a piece of pie with no name or date; an open bottle of Pepsi with no name or date. Observations of a freezer in the pantry used for residents revealed an</p>	F 0812		

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F 0812 SS=E	Continued from page 55 open half gallon container of ice cream with no name or date and ice packs that are used as treatments for residents. Observation of temperature logs posted on the front of the refrigerator and freezer revealed a log for the month of November 2024, with the log for the refrigerator lacking temperatures for the last five days, and the freezer log was lacking temperature for the last three days. Additionally, there was no evidence of temperatures logged for the month of December 2024. During an interview on 12/02/24, at 11:50 a.m. the Assistant Director of Nursing confirmed that the food items in the pantry refrigerator and freezer lacked names and/or dates. He/she confirmed that the ice packs used as treatments for residents were in the freezer with food and he/she confirmed that the temperature logs on the refrigerator and freezer lacked temperatures. He/she confirmed that food items should be labeled and dated, ice packs used as treatments should not be stored in the same unit with food, and temperatures of the refrigerator and freezer should be logged daily.	F 0812		

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F 0812 SS=E	Continued from page 56 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management	F 0812			

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P 4880	<p>Medical records.</p> <p>(f) In addition to the items required under 42 CFR 483.70(i) (5) (relating to administration), a resident ' s medical record shall include at a minimum:</p> <p>(i) Physicians' orders. (ii) Observation and progress notes. (iii) Nurses' notes. (iv) Medical and nursing history and physical examination reports. (v) Admission data. (vi) Hospital diagnoses authentication. (vii) Report from attending physician or transfer form. (vii) Diagnostic and therapeutic orders. (viii) Reports of treatments. (ix) Clinical findings. (x) Medication records. (xi) Discharge summary, including final diagnosis and prognosis or cause of death.</p> <p>This REGULATION is not met as evidenced by:</p>	P 4880	<p>1. Resident R72's discharge summary was opened and completed.</p> <p>2. The last 10 closed charts will be audited for discharge summaries. All closed charts will be reviewed going forward to ensure discharge summary is in the closed file.</p> <p>3. Nursing Home Administrator or designee will educate Interdisciplinary Team, which includes medical records, on discharge summaries to ensure that staff understands they have to be completed on all discharged residents and in the file prior to closing.</p> <p>4. Nursing Home Administrator or designee will audit to ensure discharge summaries are included in closed charts. Audits will be completed on all discharged residents for 2 weeks then monthly until compliance is met. Audits will be reviewed at quality assurance meetings monthly until compliance is met.</p>	<p>Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

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P 4880	Continued from page 1 Based on review of closed records and staff interview, it was determined that the facility failed to ensure that a discharge summary (a recapitulation or summary of the resident's stay and course of treatment in the facility) was completed for one of three discharged residents reviewed (Closed Record Resident CR72). Findings include: Resident CR72' clinical record revealed an admission date of 3/12/24, with diagnoses that included dementia (loss of cognitive functioning affecting a persons memory and behaviors), prostate cancer, and high blood pressure. Resident CR72's clinical record documentation dated 10/08/24, revealed Resident R72's spouse called into the facility and informed them that Resident CR72 would not be returning to the facility.	P 4880		

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P 4880	Continued from page 2 Resident CR72's closed clinical record lacked evidence of a discharge summary of Resident R72's stay. During an interview on 12/05/24, at 8:21 a.m. Regional Nurse Consultant confirmed that the closed record for Resident CR72 did not have a discharge summary included in the clinical record as required.	P 4880		
P 5520		P 5520		

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P 5520	Continued from page 3 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility will provide staff to ensure the needs of residents are met. The facility will produce daily schedule to meet the required nurse aide to resident ratios on all shifts. The Director of Nursing or designee will provide re-education on minimum nurse aide staffing ratios to Registered Nurse Supervisors and Human Resources/Scheduling who are responsible to maintain adequate nurse aide staffing and nurse aide staffing ratios. Director of Nursing or designee will educate HR/ Scheduler and RN supervisors of protocols for replacing staff related to call offs including mandating staff when replacement staff are unable to be found. The Director of Nursing or designee will meet 5x per week x4 weeks to audit daily deployment sheet for accuracy to ensure daily schedule meets nurse aide ratio. The Director of Nursing or designee will audit the hours worked to ensure that the minimum number of nurse	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

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P 5520	Continued from page 4	P 5520	<p>aide staff to resident ratios have been met using the Department of Health staffing grid x4 weeks</p> <p>The Director of Nursing or designee will audit weekly that protocols were followed when a call off occurred. This includes asking staff to stay, posting need, posting need with agencies, offering bonus, mandating when needed.</p> <p>The facility has ads posted on indeed and recently increase our shift differential for nurse aides on second and third shift with an increase in applications the last two weeks.</p> <p>The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.</p>	

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P 5520	Continued from page 5 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the Nurse Aide (NA) ratios for one NA per 10 residents during the day shift for two of 21 days, (11/05/24, and 12/01/24), one NA per 11 residents on the evening shift for one of 21 days reviewed (11/29/24), and one NA per 15 residents on the overnight shift for 11 of 21 days reviewed (11/08/24, 11/09/24, 11/17/24, 11/19/24, 11/20/24, 11/22/24, 11/27/24, 11/29/24, 11/30/24, 12/01/24, and 12/03/24). Findings include: Review of facility nursing staffing documents for the time periods from 11/03/24, through 11/09/24; 11/17/24, through 11/23/24; and 11/27/24, through 12/03/24, revealed the following NA staffing shortages for the day shift where the NA ratio was not met: 11/05/24 census of 78 residents 6.86 NAs	P 5520		

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P 5520	Continued from page 6 worked and 7.80 were required 12/01/24 census of 77 residents 7.20 NAs worked and 7.70 were required Review of facility nursing staffing documents for the time periods from 11/03/24, through 11/09/24; 11/17/24, through 11/23/24; and 11/27/24, through 12/03/24, revealed the following NA staffing shortage for the evening shift where the NA ratio was not met: 11/29/24 census of 76 residents 4.80 NAs worked and 6.91 were required Review of facility nursing staffing documents for the time periods from 11/03/24, through 11/09/24; 11/17/24, through 11/23/24; and 11/27/24, through 12/03/24, revealed the following NA staffing shortages for the overnight shift where the NA ratio was not met: 11/08/24 census of 76 residents 4.26 NAs worked and 5.07 were required	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
P 5520	Continued from page 7 11/09/24 census of 75 residents worked and 5.00 were required 4.26 NAs 11/17/24 census of 72 residents worked and 4.80 were required 3.20 NAs 11/19/24 census of 69 residents worked and 4.60 were required 4.33 NAs 11/20/24 census of 71 residents worked and 4.73 were required 4.53 NAs 11/22/24 census of 71 residents worked and 4.73 were required 4.60 NAs 11/27/24 census of 74 residents worked and 4.93 were required 4.26 NAs 11/29/24 census of 76 residents worked and 5.07 were required 4.80 NAs 11/30/24 census of 77 residents worked and 5.13 were required 3.73 NAs 12/01/24 census of 77 residents worked and 5.13 were required 3.72 NAs 12/03/24 census of 78 residents worked and 5.20 were required 4.66 NAs During an interview on 12/05/24, at 9:10 a.m. the Nursing Home Administrator confirmed that the	P 5520		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/05/2024
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P 5520	Continued from page 8 facility did not meet the minimum NA ratio for the above dates and shifts.	P 5520			
P 5530		P 5530			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
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P 5530	Continued from page 9 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility will provide staff to ensure the needs of residents are met. The facility will produce daily schedule to meet the required licensed practical nurse to resident ratios on all shifts. The Director of Nursing or designee will provide re-education on minimum licensed practical nurse staffing ratios to Registered Nurse Supervisors and Human Resources/Scheduling who are responsible to maintain adequate staffing and licensed practical nurse staffing ratios. Director of Nursing or designee will educate HR/ Scheduler and RN supervisors of protocols for replacing staff related to call offs including mandating staff when replacement staff are unable to be found. The Director of Nursing or designee will meet 5 days per week x4 weeks to audit daily deployment sheet for accuracy to ensure daily schedule meets licensed practical nurse ratio. The Director of Nursing or designee	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
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P 5530	Continued from page 10	P 5530	<p>will audit the hours worked to ensure that the minimum number of licensed practical nurse staff to resident ratios have been met using the Department of Health staffing grid x4 weeks</p> <p>The Director of Nursing or designee will audit weekly that protocols were followed when a call off occurred. This includes asking staff to stay, posting need, posting need with agencies, offering bonus, mandating when needed.</p> <p>The facility has ads posted on indeed and recently advertising our shift differential for licensed practical nurses on second and third shift with an increase in applications the last two weeks.</p> <p>The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.</p>	

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P 5530	Continued from page 11 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the Licensed Practical Nurse (LPN) ratio of one LPN per 25 residents on day shift for one of 21 days reviewed (12/01/24). Findings include: Review of facility nursing staffing documents for the time periods from 11/03/24, through 11/09/24; 11/17/24, through 11/23/24; and 11/27/24, through 12/03/24, revealed the following LPN staffing shortage for the day shift where the LPN ratio was not met: 12/01/24 census of 77 residents 3.00 LPN's worked and 3.80 were required During an interview on 12/05/24, at 9:10 a.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum LPN ratio for the above date and shift.	P 5530		

Pennsylvania Department of Health

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P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402		STREET ADDRESS, CITY, STATE, ZIP CODE: 205 WATER STREET WARREN, PA 16365		
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P 5640	Continued from page 13 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	The facility will provide staff to ensure the needs of residents are met. The facility will produce daily schedule to at least meet the required 3.2 minimum general nursing care Per Patient Day hour requirement. The Director of Nursing or designee will provide re-education on minimum general nursing care staffing hours to Registered Nurse Supervisors and Human Resources/Scheduling who are responsible to maintain adequate general nursing care staffing hours. Director of Nursing or designee will educate HR/ Scheduler and RN supervisors of protocols for replacing staff related to call offs including mandating staff when replacement staff are unable to be found. The Director of Nursing or designee will meet 5 days per week x4 weeks to audit daily deployment sheet for accuracy to ensure daily schedule meets minimum general nursing care staffing PPD.	Completion Date: 01/06/2025 Status: APPROVED Date: 12/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
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P 5640	Continued from page 14	P 5640	<p>The Director of Nursing or designee will audit the hours worked to ensure that the minimum number of general nursing care staff hours have been met using the Department of Health staffing grid x4 weeks.</p> <p>The Director of Nursing or designee will audit weekly that protocols were followed when a call off occurred. This includes asking staff to stay, posting need, posting need with agencies, offering bonus, mandating when needed.</p> <p>The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395363	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
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P 5640	Continued from page 15 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet 3.2 minimum number of general nursing care hours for each 24-hour period for three of 21 days reviewed (11/29/24, 12//24, and 12//24). Findings include: Review of facility nursing staffing documents for the time periods from 11/03/24, through 11/09/24; 11/17/24, through 11/23/24; and 11/27/24, through 12/03/24, revealed the following general nursing care hours was below the minimum 3.2 per patient day (PPD) on the following days: 11/29/24 2.84 PPD 12/01/24 2.98 PPD 12/03/24 3.19 PPD During an interview on 12/05/24, at 9:10 a.m. the Nursing Home Administrator confirmed that the	P 5640		

Pennsylvania Department of Health

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P 5640	Continued from page 16 facility did not meet the 3.2 PPD minimum direct nursing care hours on the above dates.	P 5640			



Certified End Page

KINZUA NURSING AND REHAB

STATE LICENSE NUMBER: 071402

SURVEY EXIT DATE: 12/05/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD

Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY