STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395363	A. BLDG: 00 B. WING:	07/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KINZUA NURSING AND REHAB STATE LICENSE NUMBER: 071402	205 WATER STREET WARREN, PA 16365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0000	INITIAL COMMENT Based on an Abbreviated Complaint Survey completed on July 25, 2025, 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.	F 0000		
F 0677 SS=D		F 0677		

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 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	1) Resident 3 and Resident 4 were showered, and shower documentation was completed 2) Director of nursing or designee audited current residents to ensure showers are ordered correctly and documentation complete, 3) Director of nursing or designee educated current direct care staff on shower policy and documentation of showers 4) Director of nursing or designee will audit 5 residents 3x per week for 2 weeks and then monthly to ensure shower offered/provided until compliance is met. Results of audits will be reviewed in QAPI each month until compliance is met. UPDATE: Audits will include documentation if refusal or change in schedule. Cognitively impaired residents will be visualized for cleanliness: hair,nails, general appearance.	Completion Date: **09/03/2025** Status: **APPROVED** Date: **08/15/2025**

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F 0677 SS=D	Continued from page 2 Based on review of facility policies, clinical records, resident and staff interview, it was determined that the facility failed to provide a bath/shower per resident preference and failed to ensure that residents received assistance with bathing for two of 12 residents reviewed (Residents R3 and R4). Findings include: Review of facility policy entitled Bed Bath, Shower/Tub dated 12/2/24, indicated The purpose of this procedure are to promote cleanliness, provide comfort to the resident ... and Documentation 1. The date and time the shower/tub or bed bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub or bed bath. Review of Resident R3s clinical record revealed an admission date of 4/4/25, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow) and hypertension (high blood pressure).	F 0677		

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F 0677 SS=D	Continued from page 3 Review of Resident R3s physician's orders dated 4/8/25, revealed an order for shower every Wednesday and Saturday on evening shift. Review of Resident R3s task (an area where the nursing assistants document) for showers revealed he/she did not receive a shower on 7/5/25, and 7/19/25. Interview with Resident R3 on 7/23/25, at 10:30 a.m. revealed that he/she was very upset over not receiving their shower. He/she stated I want a shower, the staff told me I would get one this morning and its 10:30 a.m. Look at my hair it's greasy. Now its almost lunch time and they will say they do not have the time to give me a shower. This is not the first time I waited a week to get a shower. Observations on 7/23/25, at 10:30 a.m. during the interview with Resident R3 revealed his/her hair appeared greasy and unkempt.	F 0677		

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F 0677 SS=D	Continued from page 4 Review of Resident R4s clinical record revealed an admission date of 1/9/24, with diagnoses that included Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat) and also identified their need for assistance with personal care. Review of Resident R4s physician's orders dated 4/24/25, revealed an order for shower every Tuesday and Friday on evening shift. Review of Resident R4s task for showers revealed he/she did not receive a shower on 7/11/25, 7/15/25, 7/18/25, and 7/22/25. Observations on 7/23/25, at 11:05 a.m. of Resident R4 revealed his/her hair appeared greasy and unkempt. During an interview on 7/23/25, at 1:00 p.m. the Director of Nursing (DON) confirmed that Residents R3 and R4 had not received showers as ordered and their hair appeared greasy and	F 0677		

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F 0677 SS=D	Continued from page 5 unkempt. The DON also confirmed that residents should receive their showers as ordered. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0677		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 6 483.25 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	1) R1 received medication 2) Director of nursing or designee audited current new residents admitted within the last 30 days with controlled substance orders to ensure no delay in medication administration and medication availability 3) Director of nursing or designee educated Registered Nurses to receive pull code for controlled substances upon admission of new residents with narcotics. 4) Director of nursing or designee will audit new controlled substance orders for availability by either receiving pull code from emergency kit, having pharmacy perform stat run or utilizing a local back up pharmacy to obtain medications, weekly for 2 weeks and then monthly until compliance is met. Results of audits will be reviewed in QAPI each month until compliance is met	Completion Date: **09/03/2025** Status: **APPROVED** Date: **08/14/2025**

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F 0684 SS=D	Continued from page 7 Based on review of facility policies, clinical records and staff interviews, it was determined that the facility failed to take appropriate timely action to obtain a medication for one of 12 residents reviewed (Resident R1). Findings include: Review of a facility policy entitled Administering Medication dated 12/2/24, indicated medications are administered in a safe and timely manner, as prescribed. Review of a facility policy entitled Medications Ordering and Receiving from Pharmacy dated 12/2/24, indicated medications and related products are received from the dispensing pharmacy on a timely basis. Review of facility policy entitled Medication orders dated 12/2/24, indicated a verbal prescription for a scheduled II medication may be called in to a pharmacist directly by the prescriber ... The supply	F 0684		

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F 0684 SS=D	Continued from page 8 can be delivered from the pharmacy or may be available from the emergency kit. Review of Resident R1s clinical record revealed an admission date of 6/23/25, with diagnoses that included encounter for palliative care (care and comfort measures), hypertension (high blood pressure), and dementia (a disease that affects short term memory and the ability to think logically). Review of Resident R1s nursing documentation revealed that on 6/21/25, at 8:00 p.m. the facility staff called the hospital for an update on Resident R1. The hospital staff informed the facility that Resident R1 was placed under comfort measures only. Further review of nursing documentation revealed a note dated 6/23/35, at 3:54 p.m. that Resident R1 returned to the facility and upon return, Resident R1 was not responding to verbal or physical touch was having agonal (gasping and/or labored) breathing and received morphine before leaving the hospital.	F 0684		

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F 0684 SS=D	Continued from page 9 Review of Resident R1s clinical recorded revealed discharge orders from the hospital with an order for morphine 5-20 mg (milligrams) by mouth every 30 minutes for pain or dyspnea (difficulty breathing and/or shortness of breath). Review of Resident R1s facility physician's orders revealed an order dated 6/23/25, for morphine 20 mg per ml (milliliter) give 5 ml by mouth every 4 hours as needed. Review of Resident R1s admission/re-admission evaluation dated 6/23/25, revealed under the pain evaluation Does the patient have a diagnosis or disease condition that causes or is likely to cause pain or discomfort? The answer was marked as yes. Further review of Resident R1s admission/re-admission evaluation revealed a base line care plan for pain with an intervention to administer medication per physician's orders. Review of Resident R1s pain scale revealed on 6/23/25, at 10:51 p.m. a pain scale with advanced	F 0684		

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F 0684 SS=D	Continued from page 10 dementia (a pain scale where you observe signs of pain in a resident when they are unable to tell you their pain) was marked as 4 with details (observed signs of pain) of breathing score of a 2 for observations of noisy labored breathing, long period of hyperventilation, Cheyne stokes (an irregular breathing pattern) respiration and score of a 2 for observations of facial grimacing. Another pain scale with advanced dementia on 6/24/25, at 7:13 a.m. was marked as 4 with details of breathing score of a 2 for observations of noisy labored breathing, long period of hyperventilation, Cheyne stokes respiration and score of a 2 for observations of facial grimacing. Review of Resident R1s June 2025, medication administration record revealed that morphine was not given until 10:43 a.m. on 6/24/25. During an interview with Registered Nurse Employee E1, he/she revealed that it can take between 30 minutes to two hours to pull a controlled medication out of the facilities dispensing	F 0684		

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F 0684 SS=D	Continued from page 11 unit in the facility. He/she said that the process is to notify the physician and then the physician must speak to the pharmacist then the facility would receive a pull code (permission to remove a controlled medication from the dispensing unit). He/she expressed the time depends on the physician and pharmacist communication with each other. He/she also expressed that it may take longer depending on the day and/or time of day. During an interview on 7/25/25, at 1:00 p.m. with the Director of Nursing (DON) confirmed that the facility did not get a pull code for Resident R1s morphine until 6/24/25, at approximately 10:30 a.m. The DON confirmed that Resident R1 returned to the facility with an order for morphine on 6/23/25. The DON also confirmed that Resident R1 had a pain scale of four on two different occasions prior to the morphine being obtained and that an as needed medication should be available and administered per physician's orders. 28 Pa. Code 201.18(b)(1) Management	F 0684		

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F 0684 SS=D	Continued from page 12 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0684		
F 0755 SS=D		F 0755		

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F 0755 SS=D	Continued from page 13 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 0755	1) Medical Director was made aware of R2 order and missed administration. Medical Director did not wish to order Caladryl based on current clinical presentation. 2) Director of nursing or designee audited not administered medication pass of current residents to ensure current medications are available to be administered no delay in medication administration 3) Director of nursing or designee educated licensed staff on policy for ordering medications from pharmacy. 4) 8) Director of nursing or designee will audit medication administration records for missed doses ensuring availability of medication 5x per week for 2 weeks and then monthly until compliance is met. Results of audits will be reviewed in QAPI each month until compliance is met UPDATE: Education will include the path to follow if a medication is not available: Make RN aware. Check medbank. Contact pharmacy. Notify physician. Follow physcian orders. Document. Notify family if	Completion Date: **09/03/2025** Status: **APPROVED** Date: **08/15/2025**

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F 0755 SS=D	Continued from page 14 This REQUIREMENT is not met as evidenced by:	F 0755	applicable. Pharmacy does notify if a medication is unavailable	

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F 0755 SS=D	Continued from page 15 Based on review of facility policy and clinical record review and staff interview, it was determined that the facility failed to ensure that medication was obtained and provided as ordered by the physician for one of 12 residents reviewed (Resident R2). Findings include: Review of facility policy entitled Administering Medications dated 12/2/24, indicated Medications are administered in accordance with prescriber orders, including any required time frame. Review of facility policy entitled Medication Orders dated 12/2/24, indicated The prescriber is contacted by nursing for directions when delivery of a medication will be delayed, or the medication is not or will not be available. Review of Resident R2s clinical record revealed an admission date of 4/8/25, with diagnoses that included diabetes (a health condition that caused by the bodys inability to produce enough insulin),	F 0755		

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F 0755 SS=D	Continued from page 16 hypertension (high blood pressure), and Gastro Esophageal Reflux Disease (a condition when stomach acid repeatedly flows back up into your throat). Review of Resident R2s clinical record revealed a physicians order for caladryl external lotion 1-8% apply to rash topically two times a day for seven days dated 6/26/25. Review of his/her treatment record for the months of June and July 2025, lacked evidence that caladryl lotion was applied per physicians order. Review of nursing documentation revealed the facility was waiting delivery of the caladryl lotion from the pharmacy. During an interview on 7/25/25, at 1:05 p.m. the Director of Nursing (DON) confirmed that there was no documented evidence that the caladryl lotion was received from the pharmacy or applied to Resident R2 per physician order. The DON also confirmed that the caladryl lotion should have been obtained from pharmacy and applied per physician order.	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395363	A. BLDG: __00_____ B. WING: _____	07/25/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
KINZUA NURSING AND REHAB STATE LICENSE NUMBER: **071402**	**205 WATER STREET** **WARREN, PA 16365**

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F 0755 SS=D	Continued from page 17 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. code 211.12(d)(1)(3)(5) Nursing services	F 0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 1 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.	Completion Date: **09/03/2025** Status: **APPROVED** Date: **08/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 2	P 5520	The Director of Nursing or designee will audit the hours worked to ensure that the minimum number of nurse aide staff to resident ratios have been met using the Department of Health staffing grid x4 weeks 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. 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. The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 3 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the one NA per 10 residents for the day shift for four of 21 days reviewed (7/2/25, 7/18/25, 7/19/25, and 7/20/25) and failed to meet the one NA per 11 residents for evening shift for two of 21 days reviewed (7/5/25 and 7/18/25). Findings include: Review of nursing staffing documents for the time period of 7/1/25, through 7/21/25, revealed the following NA staffing shortages for the day shift: 7/2/25, facility census of 86 residents, 8.53 NA scheduled and 8.60 were required. 7/18/25, facility census of 82 residents, 7.97 NA scheduled and 8.20 were required. 7/19/25, facility census of 82 residents, 7.63 NA scheduled and 8.20 were required. 7/20/25, facility census of 83 residents, 7.90 NA scheduled and 8.30 were required.	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 4 Review of nursing staffing documents for the time period of 7/1/25 through 7/21/25, revealed the following NA staffing shortages for the evening shift: 7/5/25, facility census of 86 residents, 7.67 NA scheduled and 7.82 were required. 7/18/25, facility census of 82 residents, 6.93 NA scheduled and 7.45 were required During an interview on 7/24/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum NA ratio requirements on the above shifts and dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 5 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	Completion Date: 09/03/2025 Status: APPROVED Date: 08/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 6	P 5530	accuracy to ensure daily schedule meets licensed practical nurse ratio. The Director of Nursing or designee 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 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. 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. The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 7 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the one Licensed Practical Nurse (LPN) ratios of one LPN per 25 residents on the day shift for 11 of 21 days reviewed (7/1/25, 7/5/25, 7/6/25, 7/8/25, 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/18/25, 7/20/25 and 7/21/25); failed to meet the ratio ofone LPN per 30 residents on the evening shift for one of 21 days reviewed (7/2/25) and failed to meet the ratio of one LPN per 40 residents on the overnight shift for four of 21 days reviewed (7/2/25, 7/5/25, 7/8/25, and 7/18/25). Findings include: Review of nursing staffing documents for the time period of 7/1/25, through 7/21/25, revealed the following LPN staffing shortages for the day shift: 7/1/25, facility census of 84 residents, 3.09 LPN worked and 3.36 were required. 7/5/25, facility census of 85 residents, 3.09 LPN	P 5530		

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P 5530	Continued from page 8 worked and 3.40 were required. 7/6/25, facility census of 86 residents, 3.03 LPN worked and 3.44 were required. 7/8/25, facility census of 85 residents, 3.09 LPN worked and 3.40 were required. 7/11/25, facility census of 81 residents, 3.13 LPN worked and 3.24 were required. 7/12/25, facility census of 81 residents, 3.13 LPN worked and 3.24 were required. 7/13/25, facility census of 80 residents, 3.06 LPN worked and 3.20 were required. 7/14/25, facility census of 79 residents, 2.88 LPN worked and 3.16 were required. 7/18/25, facility census of 82 residents, 3.00 LPN worked and 3.28 were required. 7/20/25, facility census of 83 residents, 3.19 LPN worked and 3.32 were required. 7/21/25, facility census of 83 residents, 3.00 LPN worked and 3.32 were required. Review of nursing staffing documents for the time period of 7/1/25 through 7/21/25, revealed the following LPN staffing shortages for the evening	P 5530		

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P 5530	Continued from page 9 shift: 7/2/25, facility census of 86 residents, 2.13 LPN worked and 2.87 were required. Review of nursing staffing documents for the time period of 7/1/25 through 7/21/25, revealed the following LPN staffing shortages for the overnight shift: 7/2/25, facility census of 86 residents, 2.09 LPN worked and 2.15 were required. 7/5/25, facility census of 86 residents, 2.09 LPN worked and 2.15 were required. 7/8/25, facility census of 86 residents, 2.03 LPN worked and 2.10 were required. 7/18/25, facility census of 82 residents, 2.00 LPN worked and 2.05 were required. During an interview on 7/24/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum LPN ratio requirements on the above shifts and dates.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 10	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 11 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	Completion Date: 09/03/2025 Status: APPROVED Date: 08/14/2025

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P 5640	Continued from page 12	P 5640	meets minimum general nursing care staffing PPD. 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. 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. The results of these audits will be reviewed at Quality Assurance and Process Improvement meetings until substantial compliance is achieved.	

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P 5640	Continued from page 13 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to provide the minimum number of general nursing care hours of 3.20 hours of direct resident care hours per resident in a twenty-four hour period for three of 21 days reviewed (7/5/25, 7/6/25, and 7/20/25). Findings include: Review of facility nursing staffing documents for the time period of 7/1/25, through 7/21/25, revealed that the hours of direct resident care was below 3.20 minimum per patient day (PPD) on the following dates: 7/5/25 3.16 PPD 7/6/25 3.19 PPD 7/20/25 3.17 PPD During an interview on 7/24/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to meet the minimum PPD	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 14 requirements on the above dates.	P 5640		

Certified End Page

KINZUA NURSING AND REHAB

STATE LICENSE NUMBER: 071402

SURVEY EXIT DATE: 07/25/2025

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
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