

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201
STATE LICENSE NUMBER: 234802	

(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
E 0000	INITIAL COMMENT	E 0000		
E 0036	Based on an Emergency Preparedness Survey completed on January 22, 2025, it was determined that Kittanning Health and Rehab Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0036		
SS=F				

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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E 0036 SS=F	Continued from page 1 483.73(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be	E 0036	The Emergency Preparedness Plan (EPP) was reviewed and updated as necessary. The Emergency Preparedness Plan to be reviewed and updated at least annually based on the most recent documented, facility-based and community-based risk assessment using an all-hazards approach. NHA/designee to complete annual full-scale exercise/table-top exercise by 21MAR2025. NHA/designee to educate all staff by 21MAR2025 on the Emergency Preparedness Plan and annual testing requirements to ensure a comprehensive understanding of policies and procedures and staff readiness. RVPO/designee to educate NHA by 21MAR2025 on the requirements of Emergency Preparedness Plan Guidelines and staff annual EPP training requirements.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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E 0036 SS=F	Continued from page 2 reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by:	E 0036	To prevent this from recurring, RVPO will complete annual audits on facility EPP to ensure current updated version. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendation	

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E 0036 SS=F	Continued from page 3 Based on document review and interview, the facility failed to develop an emergency preparedness plan that included annual emergency preparedness plan staff training for one of one plan. Findings include: Document review on January 22, 2025, at 9:50 a.m., revealed the facility lacked documentation that all staff had annual emergency preparedness training and testing within the previous twelve months. Interview with the maintenance supervisor on January 22, 2025, at 9:50 a.m., confirmed the facility lacked the training documentation.	E 0036		
E 0039 SS=E		E 0039		

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E 0039 SS=E	Continued from page 4 483.73(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 0039	The Emergency Preparedness Plan (EPP) was reviewed and updated as necessary. The Emergency Preparedness Plan to be reviewed and updated at least annually based on the most recent documented, facility-based and community-based risk assessment using an all-hazards approach. NHA/designee to complete annual full-scale exercise/table-top exercise by 21MAR2025. NHA/designee to educate all staff by 21MAR2025 on the EPP to ensure a comprehensive understanding of policies and procedures to ensure staff readiness. RVPO/designee to educate NHA by 21MAR2025 on the requirements of Emergency Preparedness Plan Guidelines. To prevent this from recurring, RVPO will complete annual audits on facility EPP to ensure current	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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E 0039 SS=E	Continued from page 5 (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite	E 0039	updated version. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendation	

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E 0039 SS=E	Continued from page 6 the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E 0039		

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E 0039 SS=E	Continued from page 7 (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based	E 0039		

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E 0039 SS=E	Continued from page 8 or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may	E 0039		

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E 0039 SS=E	Continued from page 9 include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 10 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 11 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.	E 0039		

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E 0039 SS=E	Continued from page 12 (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise	E 0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
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E 0039 SS=E	Continued from page 13 following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by:	E 0039		

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E 0039 SS=E	Continued from page 14 Based on document review and interview, the facility failed to maintain emergency preparedness guidelines for one of one emergency preparedness plan. Findings include: Document review on January 22, 2025, at 9:55 a.m., revealed the facility lacked records to annually full-scale exercise, test, evaluate, and table-top exercise the emergency preparedness plan. The facility also lacked a table-top exercise. Interview with the maintenance supervisor on January 22, 2025, at 9:55 a.m., confirmed the lack of documentation.	E 0039		



Certified End Page

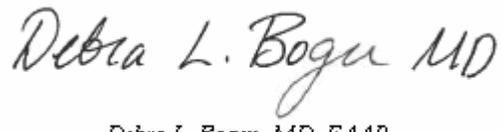
KITTANNING HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 234802

SURVEY EXIT DATE: 01/22/2025

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID 234802 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 22, 2025, it was determined that Kittanning Health and Rehab Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.9 (a).</p> <p>This is a one-story, Type II (000), unprotected, non-combustible building, with a partial basement, that is fully sprinklered.</p>	K 0000		

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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K 0100 SS=F	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	Maintenance immediately cleaned and tested carbon monoxide detectors throughout the building and documented the results. Maintenance completed audit of carbon monoxide detectors throughout the facility to ensure function and documented with no negative findings. NHA/Designee to educate Maintenance department by 21MAR2025 on the importance of maintaining proper service records for cleaning/testing of carbon monoxide detectors To prevent this from recurring Maintenance will perform weekly x4 audits on carbon monoxide detectors for cleanliness and function. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0100 SS=F	Continued from page 2 Based on document review and interview, the facility failed to test and clean carbon monoxide detectors throughout the building, per PA Act #45. Findings include: Document review on January 22, 2025, at 10:20 a.m., revealed the facility lacked documentation that the carbon monoxide detectors were cleaned/tested for eight of the previous twelve months. ***The facility stated that documents were destroyed due to a water leak.*** Interview with the maintenance supervisor on January 22, 2025, at 10:20 a.m., confirmed the facility lacked the cleaning/testing documentation.	K 0100		

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K 0211 SS=E		K 0211		
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K 0211 SS=E	Continued from page 4 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	A. Discharge door not maintained: Maintenance immediately removed snow from sidewalk from the exit discharge door near time clock area Maintenance completed audit of all exit discharge doors to ensure clear egress NHA/designee educated maintenance staff by 21MAR2025 on snow removal policy Maintenance will complete snow removal of discharge exit doors as per policy whenever weather occurs. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Discharge door failed to be equipped with panic or fire exit hardware Maintenance replaced panic bar hardware on exit door near employee lounge. Maintenance completed audit of all	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0211 SS=E	Continued from page 5	K 0211	<p>exit doors to ensure proper function. NHA/designee educated maintenance staff by 21MAR2025 on proper exit door function and maintenance.</p> <p>To prevent this from recurring Maintenance will perform weekly audits on exit door hardware/function and document. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p>	

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K 0211 SS=E	Continued from page 6 Based on observation and interview, the facility failed to maintain the egress discharges at two of six exit discharges. Findings Include: Observation and interview on January 22, 2025, between 8:49 a.m. and 8:56 a.m. revealed the exit discharge deficiencies: A. (8:49 a.m.) The exit discharge door near the time clock room, the exterior egress path was not maintained and was snow-covered at the time of the survey; B. (8:56 a.m.) The exit discharge door near the employee lounge failed to be equipped with panic or fire exit hardware at the time of the survey. Interview with the maintenance supervisor on January 22, 2025, at 8:56 a.m., confirmed the exit discharge discrepancies.	K 0211		

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K 0211 SS=E	Continued from page 7	K 0211		
K 0223 SS=E		K 0223		

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K 0223 SS=E	Continued from page 8 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	A. Laundry wet/dry room failed to latch: Maintenance replaced door handle to properly latch in laundry wet/dry room. Maintenance did audit of all self-closing device doors to ensure proper door latch function. NHA/designee to education maintenance department by 21MAR2025 on the importance of ensuring door handles are operating properly. To prevent this from recurring Maintenance will perform weekly x 4 audits on door latch function. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Laundry wet room door propped open: Maintenance immediately removed the cart from the open laundry/wet	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0223 SS=E	Continued from page 9	K 0223	<p>room door. Maintenance did a whole house audit making sure no doors being propped open. Maintenance/designee to educate staff by 21MAR2025 on importance of not using items to hold doors open and having doors remain securely closed. To prevent this from recurring Maintenance will perform weekly x 4 audits to ensure doors are not being propped open. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>C. Laundry soiled utility room failed to close/dragging: Maintenance adjusted laundry soiled utility room door to not drag on the floor and ensured properly closing. Maintenance completed an audit on</p>	

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K 0223 SS=E	Continued from page 10	K 0223	<p>all doors to ensure laundry soiled doors are closing properly. NHA/designee to educate maintenance staff by 21MAR2025 on importance of proper closure of all doors. To prevent this from recurring Maintenance will perform weekly audits to ensure all doors are closing properly. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>D. Kitchen door to exterior failed to close and latch Maintenance installed a magna lock with keypad to secure exterior kitchen door. Maintenance completed audit on all doors to ensure exterior kitchen door closed and latched properly. NHA/designee to educate maintenance staff by 21MAR2025 on</p>	

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K 0223 SS=E	Continued from page 11	K 0223	<p>importance of proper closure and latch of all exit doors. To prevent this from recurring Maintenance will perform weekly audits to ensure proper closure and latching of doors. Negative findings will be addressed. Ad Hoc education will be provided. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>E. Kitchen dishwashing door failed to close and latch in frame Maintenance adjusted kitchen dishwashing room door to close and latch properly. Maintenance completed audit on all doors to ensure closing and latch properly. Maintenance/designee will educate kitchen staff by 21MAR2025 on importance of ensuring proper closure and latching of all doors. To prevent this from recurring</p>	

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K 0223 SS=E	Continued from page 12	K 0223	<p>Maintenance will perform weekly x4 audits to ensure entry and exit doors are closing and latching. Negative findings will be addressed. Ad Hoc education will be provided.</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>F. Unit 1 Fire Door near #127 failed to latch in frame Maintenance adjusted Unit 1 fire door to ensure door closed and latched properly. Maintenance completed audit on all fire doors to ensure closing and latching properly. NHA/Designee to educate maintenance staff by 21MAR2025 on importance of doors closing properly. Maintenance will do weekly x4 audit on all fire doors to ensure closing and latching properly. Negative findings will be addressed accordingly. Ad Hoc education as needed</p>	

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K 0223 SS=E	Continued from page 13	K 0223	<p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>G. Unit 2 Fire Door failed to latch in frame Maintenance adjusted Unit 2 fire door to ensure closed and latched properly. Maintenance completed audit on all fire corridor doors to ensure closing and latching properly.</p> <p>NHA/Designee to educate maintenance staff by 21MAR2025 on importance of doors closing properly.</p> <p>Maintenance will do weekly x 4 audits on all unit entry and exit fire doors to ensure closing and latching properly. Negative findings will be addressed accordingly. Ad Hoc education as needed.</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: 234802	STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201
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K 0223 SS=E	Continued from page 14	K 0223	Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
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K 0223 SS=E	Continued from page 15 Based on observation and interview, the facility failed to maintain doors with self-closing devices for seven of over ten doors. Findings include: Observation on January 22, 2025, between 9:00 a.m. and 10:18 a.m., revealed the following self-closing door deficiencies: A. (9:00 a.m.) Laundry wet/dry room door failed to positively latch in the frame; B. (9:01 a.m.) Laundry wet room door was propped open; C. (9:02 a.m.) Laundry soiled utility room failed to close and was dragging on the floor; D. (9:34 a.m.) Kitchen door to the exterior failed to close and latch in the frame; E. (9:38 a.m.) Kitchen dishwashing door failed to close and latch in the frame; F. (9:41 a.m.) Unit 1 fire door, near resident room #127, failed to latch in the frame; G. (10:18 a.m.) Unit 2 corridor fire door failed to latch in the frame.	K 0223		

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NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
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K 0223 SS=E	Continued from page 16 Interview with the maintenance supervisor on January 22, 2025, at 10:18 a.m., confirmed the self-closing door deficiencies.	K 0223		
K 0291 SS=F		K 0291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0291 SS=F	Continued from page 17 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	A. Monthly 30-second testing Maintenance performed emergency 30-second lighting test and documented testing results. Maintenance will maintain monthly audit of 30-second lighting testing and documentation. NHA/Designee to educated Maintenance staff by 21MAR2025 on emergency lighting 30-second testing and maintaining documentation. Maintenance Director/Designee to complete monthly x3 audit of emergency lighting test documentation. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Annual 90-min testing Maintenance will complete 90 minute annual testing by 3/21/25 and document. Maintenance will complete annual testing thereafter.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0291 SS=F	Continued from page 18	K 0291	NHA/Designee will educate maintenance staff by 21MAR2025 on emergency lighting 90-min testing and documenting annually to remain in compliance. NHA/Designee to complete routine audits of maintenance documentation records. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0291 SS=F	Continued from page 19 Based on observation, document review, and interview, the facility failed to maintain emergency lighting, in accordance with regulations, affecting the entire facility. Findings include: Document review on January 22, 2025, at 11:20 a.m., revealed the facility could not provide documentation for the following emergency lighting tests for the previous 12 months: A. Monthly 30-second testing; B. Annual 90-min testing. Interview with the maintenance supervisor on January 22, 2025, at 11:20 a.m., confirmed the missing documentation.	K 0291		
K 0293 SS=F		K 0293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0293 SS=F	Continued from page 20 NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	A. MIU Courtyard Door: Maintenance immediately removed all blinds that were covering court yard "NOT AN EXIT" sign. Maintenance completed exit sign inspection and documented findings. No additional negative findings. NHA/Designee to educate maintenance staff by 21MAR2025 on exit signage visibility. Maintenance/designee will complete weekly x 4 audits of exit signage to ensure proper display. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Facility couldn't provide documentation for monthly 12 month exit sign inspection: Maintenance performed immediate exit sign inspection and documented findings.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0293 SS=F	Continued from page 21	K 0293	Maintenance will keep proper documentation for monthly exit sign inspection. NHA/Designee will educate Maintenance staff by 21MAR2025 on exit sign inspection and documentation. NHA/Designee will complete exit sign inspection documentation audits monthly x 3 audits to ensure proper inspection and documentation. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0293 SS=F	Continued from page 22 Based on documentation review, observation, and interview, the facility failed to maintain exit and directional signage for the entire building. Findings include: Documentation review, observation, and interview on January 22, 2025, between 9:57 a.m. and 11:35 a.m. revealed the following signage deficiencies: A. (9:57 a.m.) MIU unit courtyard doors had blinds covering the NOT AN EXIT signs; B. (11:35 a.m.) Facility could not provide documentation for monthly exit sign inspections for the previous 12 months. Interview with the maintenance supervisor on January 22, 2025, at 11:35 a.m., confirmed the signage deficiencies.	K 0293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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K 0324 SS=E		K 0324		
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K 0324 SS=E	Continued from page 24 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	A. Kitchen staff uncertain of hood fire suppression Dietary Director immediately educated dietary staff on the location and proper operation of hood fire suppression system. Dietary Director/ Designee to complete education to kitchen/dietary staff by 21MAR2025 to ensure certainty of location and operation of the hood fire suppression systems manual activation. Dietary Manager/Designee to complete annual educations ensuring dietary staff are aware of kitchen equipment and safety. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Hood Suppression Inspection 2x in prior year. –	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0324 SS=E	Continued from page 25	K 0324	<p>Maintenance to schedule and complete hood suppression inspection and document per maintenance schedule.</p> <p>Maintenance to obtain and maintain documentation and have it readily available by 21MAR2025.</p> <p>NHA/Designee to educate staff by 21MAR2025 on importance of completing hood suppression 2x per year and obtaining proper documentation.</p> <p>NHA/Designee to audit hood suppression inspection documentation monthly every 6months. Negative findings will be addressed accordingly. Ad Hoc education as needed.</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p>	

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K 0324 SS=E	Continued from page 26 Based on observation, document review, and interview, the facility failed to maintain cooking equipment in one of one kitchen. The facility failed to ensure the kitchen suppression system was inspected and serviced at required intervals for one of two inspections. Findings include: Document review, observation, and interview on January 22, 2025, between 9:32 a.m. and 10:10 a.m., revealed the following kitchen deficiencies: A. (9:32 a.m.) Kitchen staff members interviewed were uncertain of the location and operation of the hood fire suppression system's manual activation; B. (10:10 a.m.) Facility could not produce documentation that a kitchen suppression inspection had been performed twice in the prior year. Interview with the maintenance supervisor on January 22, 2025, at 10:10 a.m., confirmed the kitchen cooking equipment deficiencies.	K 0324		

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K 0324 SS=E	Continued from page 27	K 0324		
K 0345 SS=F	<p>NFPA 101 Fire Alarm System - Testing and Maintenance</p> <p>Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0345	<p>A. Fire Alarm Panel "Trouble": Maintenance director immediately contacted Alti Protection to perform service on fire alarm panel and clear service mode. NHA/Designee to educate maintenance staff by 21MAR2025 on the fire control panel and service documentation. Maintenance Director/designee will audit monthly x 3 Negative findings will be addressed accordingly. Ad Hoc education as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p> <p>B. Sensitivity Test: Maintenance director obtained the 2 year sensitivity smoke detectors test from 3/25/2024.</p>	<p>Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025</p>

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K 0345 SS=F	Continued from page 28 Based on document review, observation, and interview on January 22, 2025, between 8:45 a.m. and 10:25 a.m., the facility failed to maintain the fire alarm system and testing, affecting the entire building. Findings include: A. (8:45 a.m.) Observation revealed the fire alarm panel read "Service mode, System being service, TROUBLE"; B. (10:25 a.m.) Facility lacked two-year smoke detector sensitivity testing documentation at the time of the survey. Interview with the maintenance supervisor on January 22, 2025, at 10:25 a.m., confirmed the deficiencies.	K 0345		

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K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 30 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	A. Kitchen Sprinkler Heads dust-covered Maintenance cleaned kitchen sprinkler heads identified. Maintenance completed audit of whole house sprinkler heads, cleaned the sprinkler heads of dust and changed escutcheons as needed. NHA/Designee to educate maintenance staff by 21MAR2025 on importance of dust free, corrosion free sprinkler heads/escutcheons. Maintenance to complete weekly x4 audits of kitchen sprinklers. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. 3rd Quarter Sprinkler Documentation Maintenance immediately completed sprinkler head audit. Maintenance will maintain	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0353 SS=F	Continued from page 31	K 0353	documentation of inspections. NHA/Designee to educate maintenance staff by 21MAR2025 on the importance of completing sprinkler maintenance and maintaining inspection documentation. NHA/designee will complete quarterly x3 documentation audit to ensure sprinkler system maintenance documentation is complete. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the quarterly audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
STATE LICENSE NUMBER: 234802				
(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
K 0353 SS=F	Continued from page 32 Based on observation and interview, the facility failed to remain in compliance with sprinkler system regulations of one of one system. Findings include: Document review on January 22, 2025, between 9:34 a.m., and 10:45 a.m. revealed the following deficiencies: A. (9:36 a.m.) Kitchen dishwashing area sprinkler heads were dust-covered, dirty, and corroded; B. (10:45 a.m.) Third quarter sprinkler system inspection documentation was unavailable at the time of the survey. Interview with the maintenance supervisor on January 22, 2025, at 10:45 a.m., confirmed the sprinkler system deficiencies.	K 0353		
K 0363 SS=B		K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: 234802		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
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K 0363 SS=B	Continued from page 33 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	Maintenance immediately adjusted room 129 door to ensure closure and latch properly. Maintenance audited all resident doors to ensure doors were operating correctly. Maintenance director/designee to educate maintenance staff by 21MAR2025 on importance of proper door closure. Maintenance Director/designee will do weekly x4 audit of all resident room doors to make sure that doors are closing and latching correctly. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0363 SS=B	Continued from page 34 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet corridor door requirements for one of over twenty corridor doors. Findings include: Observation on January 22, 2025, at 9:42 a.m., revealed resident room #129 failed to positively latch in the frame. Interview with the maintenance supervisor on January 22, 2025, at 9:42 a.m., confirmed the corridor door deficiency.	K 0363		
K 0372 SS=D		K 0372		

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K 0372 SS=D	Continued from page 35 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Maintenance replaced damaged and deficient ceiling tiles. Maintenance completed whole house audit to identify deficient ceiling tiles. NHA/Designee to educate maintenance staff by 21MAR2025 on importance of ceiling tiles to ensure proper function for smoke barrier. Maintenance/designee to complete audits weekly x 4 of ceiling tiles. Negative findings will be addressed accordingly. Ad Hoc education as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0372 SS=D	Continued from page 36 Based on observation and interview, the facility failed to maintain smoke barriers in over thirty rooms affecting one of one component. Findings include: Observation on January 22, 2025, between 8:45 a.m. and 10:15 a.m., revealed multiple ceiling tiles that lacked maintenance throughout the main floor. There were loose, misaligned, damaged, and missing tiles in various locations. Additionally, five rooms in the basement area were affected by a recently frozen/ ruptured pipe that caused water damage to numerous ceiling tiles. The tiles were removed due to the water damage and also to make repairs to the piping. The missing ceiling tiles can delay activation of the fire system components and allow passage of smoke. Interview with the maintenance supervisor on January 22, 2025, at 10:15 a.m., confirmed the smoke barrier deficiencies at the time of the survey.	K 0372		

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K 0372 SS=D	Continued from page 37	K 0372		
K 0712 SS=F	<p>NFPA 101 Fire Drills</p> <p>Fire Drills</p> <p>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0712	<p>Fire Drill conducted immediately following the safety survey. No negative findings identified.</p> <p>NHA/designee to educate maintenance staff by 21MAR2025 on the fire drill schedule to ensure fire drills are conducted on each shift quarterly.</p> <p>NHA/designee will monitor the fire drills and fire drill documentation quarterly x 3 to ensure they are being done on varying shifts. Negative findings will be addressed accordingly. Ad Hoc education as needed</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p>	<p>Completion Date: 03/21/2025</p> <p>Status: APPROVED</p> <p>Date: 02/10/2025</p>

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K 0712 SS=F	Continued from page 38 Based on document review and interview, the facility failed to meet fire drill requirements for 11 of 12 required drills. Findings include: Document review on January 22, 2025, at 10:15 a.m., revealed the following drills lacked documentation: A. First shift, second, third, and fourth quarters; B. Second shift, all four quarters; C. Third shift, all four quarters. ***Facility stated documents were destroyed due to a water leak.*** Interview with the maintenance supervisor on January 22, 2025, at 10:15 a.m., confirmed the deficiencies.	K 0712		

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K 0712 SS=F	Continued from page 39	K 0712		
K 0912 SS=F	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	Maintenance immediately tested electrical receptacles. Maintenance to monthly testing of electrical receptacles and maintain documentation according to compliance. NHA/Designee to educate maintenance staff by 21MAR2025 about annual receptacle testing and maintaining proper documentation. NHA/designee to audit monthly x3 for electrical receptacle testing and documentation. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0912 SS=F	Continued from page 40 Based on document review and interview it was determined that the facility failed to perform an annual test and inspection on non-hospital grade electrical receptacles in resident sleeping rooms, throughout the entire facility. Findings include: Document review on January 22, 2025, at 11:45 a.m., revealed electrical receptacles in resident care rooms were not tested for non-hospital grade receptacles at intervals not exceeding 12 months. Receptacle testing should include the following: a. Patient care rooms; b. Visual inspection of physical integrity; c. Correct polarity of the hot and neutral connections; d. Retention force of the grounding blade (except locking-type receptacles) shall be not less than 115g (4 oz). Interview with the maintenance supervisor on	K 0912		

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K 0912 SS=F	Continued from page 41 January 22, 2025, at 11:45 a.m., confirmed the lack of documentation.	K 0912		
K 0918 SS=F		K 0918		

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K 0918 SS=F	Continued from page 42 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	A. Weekly visual/inspection and battery: Maintenance initiated immediate inspection of battery and voltage test, documenting findings. Maintenance will continue to document weekly inspections. NHA/Designee will educate maintenance staff by 21MAR2025 on importance of maintaining proper documentation and electric system maintenance and testing. Maintenance director/designee will conduct weekly x4 inspections of battery and voltage test and documentation. Negative findings will be addressed accordingly. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Monthly Specific gravity or conductance 30-min load run and transfer switch.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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K 0918 SS=F	Continued from page 43 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	<p>Maintenance completed 30-minute load run specific conductance test and documented results.</p> <p>Maintenance to conduct monthly 30-min load run tests, results to be documented and kept on file.</p> <p>NHA/Designee will educate maintenance staff by 21MAR2025 on requirements to do 30-min load run and transfer switch testing monthly and document results to ensure proper function and compliance.</p> <p>Maintenance will complete monthly x 3 audit to remain in compliance. Negative findings will be addressed accordingly. Ad Hoc education as needed</p> <p>The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.</p>	

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K 0918 SS=F	Continued from page 44 Based on document review and interview, the facility failed to maintain the emergency generator, affecting the entire facility. Findings include: Document review on January 22, 2025, at 11:00 a.m., revealed the facility failed to provide documentation for the following tests for 10 of 12 months (March-December): A. Weekly visual/inspection and battery voltage or electrolyte levels; B. Monthly specific gravity or conductance, 30-minute load run, and transfer switch. ***Facility stated documents were destroyed due to a water leak.*** Interview with the maintenance supervisor on January 22, 2025, at 11:00 a.m., confirmed the test documentation was unavailable at the time of the survey.	K 0918		

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K 0918 SS=F	Continued from page 45	K 0918		
K 0920 SS=C		K 0920		

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K 0920 SS=C	Continued from page 46 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	A. Refrigerator plugged into power strip in ADMIN office: Refrigerator immediately unplugged from power strip and plugged into wall; power strip removed from administrator's office. Maintenance completed whole house audit for power strip, no additional findings. NHA/Designee will be educating maintenance staff by 21MAR2025 on regulations regarding power strips. Maintenance will complete audits weekly x 4 the building for power strips, addressing negative findings immediately. Ad Hoc education as needed. The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations. B. Unit 1 Soiled Rm. Refrigerator plugged into extension cord: Refrigerator immediately unplugged from extension cord and plugged into wall; extension cord removed from Unit 1 soiled utility room.	Completion Date: 03/21/2025 Status: APPROVED Date: 02/10/2025

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NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
STATE LICENSE NUMBER: 234802				
(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
K 0920 SS=C	Continued from page 47	K 0920	Maintenance completed whole house audit for extension cords, no additional findings. NHA/Designee will be educating maintenance staff by 21MAR2025 on regulations regarding extension cords. Maintenance will complete audits weekly x 4 throughout the building for extension cords, addressing negative findings immediately. Ad Hoc education as needed The results of the audits will be forwarded to the facility Quality Assurance Performance Improvement (QAPI) committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395986	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: KITTANNING HEALTH & REHAB CENTER STATE LICENSE NUMBER: 234802		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 KITTANNING CARE DRIVE KITTANNING, PA 16201		
(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
K 0920 SS=C	Continued from page 48 Based on observation and interview, the facility failed to maintain electrical power cords in one of one component. Findings include: Observation on January 22, 2025, between 9:08 a.m. and 9:51 a.m., revealed the following locations had electrical power cords in use: A. (9:08 a.m.) Administrator's office had a refrigerator that was plugged into a power strip. The power strip was removed during the survey; B. (9:51 a.m.) Unit 1, soiled utility room had a refrigerator plugged in an extension cord. Interview with the maintenance specialist on January 22, 2025, at 9:51 a.m., confirmed the above power cord deficiencies existed at the time of the survey.	K 0920		



Certified End Page

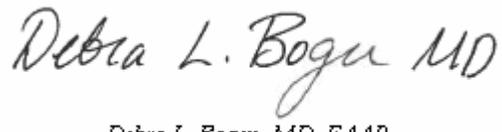
KITTANNING HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 234802

SURVEY EXIT DATE: 01/22/2025

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, 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