

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Armstrong Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 265 South McKean Street Kittanning, PA 16201	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, documents, and staff interviews, it was determined that the facility failed to ensure an environment free of hazards which is likely to cause serious injury, harm, impairment, or death when an employee (RN Employee E1) entered the facility with a shot gun and ammunition. This failure created an immediate jeopardy situation for all residents. Findings include: Review of the facility's Employee Handbook dated 6/1/21, indicated the definition of an act of violence, for purposes of this policy, the facility will interpret an act of violence whether it is physical violence, verbal or non-verbal threats, damage to or theft of property and/or any related actions in the broadest sense possible to include (but not limited to) any of the following acts on facility property or facility sponsored function. -Possession of any firearm, knife, explosive or any other type of weapon covered by the law regardless of whether the person is licensed to carry the weapon or not. The possession or use of a weapon will be cause for immediate termination of employment. -Employees are required to report incidents of workplace violence or threats of such violence to their supervisor or any member of the management team immediately. No reprisal will be taken against any employee who in good faith reports or experiences workplace violence. -If any threat of violence exists, call 911 and notify law enforcement officials of the problem and request their assistance (e.g. police and/or ambulance). Inform those involved and contact the Chief Executive Officer. Review of the facility policy Workplace Violence last reviewed 5/21/26, indicated Weapons: the facility prohibits all Associates, residents, or visitors from possessing any weapons of any kind at the workplace. For purposes of this policy, the workplace is defined to include the Facility's building(s), outdoor areas, and parking lots. Weapons include but are not limited to guns, knives, [NAME], explosives, and any item with the potential to inflict harm that has no common purpose. Review of RN Employee E1's personnel file indicated a signature sheet for the employee handbook dated 9/22/23, indicating they agree to comply with the requirements in the employee Handbook and any other personnel policies issued by the facility. Review of an anonymous complaint filed with the state on 7/15/26, the Confidential Employee E2 indicated when they arrived at the facility in their car, they saw a man walk into the facility with a shot gun and ammunition in their hand. He walked right into the facility. Before Confidential Employee E2 left the facility parking lot two staff members in scrubs were there and they said, we saw that too. That's the Registered Nurse (RN) Supervisor Employee E1 of the building for daylight shift. Interview on 7/16/26, at 9:05 a.m. Social Services Director (SSD) Employee E3 indicated they walked into the facility around 7:05 a.m. on 7/15/26, and the Infection Preventionist (IP) Employee E4 was sitting outside my office and said, Before you go in there, there is a gun in the corner that RN Employee E1 brought in because the NHA wanted to look at it. SSD Employee E3 continued to state that there were bullets with it as well. They looked at the gun, shut the door and went down the hall. They did not (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 395471
		If continuation sheet Page 1 of 5

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	indicate that they called anyone at that time. When asked if they thought it was odd that a firearm was in the facility, SSD Employee E3 indicated they did find it odd. They did not indicate they thought they should call the police. The reason they shut their office door was because it has a key code lock to enter. SSD Employee E3 indicated that herself and IP Employee E4 knew the code to the social services office door. Further interview with SSD Employee E3, indicated the Director of Nursing (DON) called the facility because she hadn't arrived yet, the DON instructed SSD Employee E3 and IP Employee E4 to go speak to RN Employee E1 on the second floor, then went outside to speak to an agency aide that was in the parking lot. Somebody arrived in a black vehicle, maybe RN Employee E1's spouse and saw RN Employee E1 give the shotgun and bullets to whomever was in the car who left the parking lot with it. SSD Employee E3 indicated they did not believe any resident saw or knew of the shotgun being in the first-floor office and that it never went to a resident unit. Telephonic interview on 7/16/26, at 9:27 a.m. with IP Employee E4 indicated whenever they were entering the facility they saw RN Employee E1 with a shotgun and asked why they had that. They responded that they were going to show it to the NHA, and they didn't want to take it to the floor. IP Employee E4 said I don't think you should have it in the facility. It was locked in SSD Employee E3's office. The DON called me and asked if RN Employee E1 was there and had him remove the gun from the facility immediately. IP Employee E4 contacted RN Employee E1 and instructed him to meet immediately at the SSD Employee E3's office entrance. RN Employee E1 then removed the shotgun from the office and took it out of the facility. One of the staff outside called the DON and that's when they received the call to remove the gun immediately. When asked if they saw the gun and why they didn't call the police, IP Employee E4 indicated they really didn't know what to do and that's why the gun was locked in the first-floor office. Interview on 7/16/26, at 9:15 a.m. the DON indicated this all occurred prior to her arrival to the facility. Once the DON arrived at facility, she called RN Employee E1 to her office and had a conversation about safety and not bringing weapons into the facility. The DON read to RN Employee E1 what they found online under Pennsylvania regulations and weapons in a long-term care facility as a very serious offense. The DON provided disciplinary action. RN Employee E1 told the DON her didn't mean anything by it, he was just going to show it to the NHA. The DON told them this can never ever happen again. RN Employee E1 stated I don't even think we have signs that say no guns. Interview on 7/16/26, at 9:35 a.m. the Nursing Home Administrator (NHA) indicated that he is a fan of guns, collects guns, and knows people that buy guns. The NHA had a conversation the day prior with RN Employee E1 who said he'd like to show a gun to me, that NHA might know someone who might want to buy it. The conversation occurred in the Social Worker's office. The NHA said according to policy the gun should not have been on the property. The NHA had a conversation with RN Employee E1 after the Director of Nursing provided disciplinary action and RN Employee E1 indicated that he used to carry the gun into this nursing home and has a permit to carry. On 7/16/26, at 11:50 a.m., the NHA and DON were made aware that Immediate Jeopardy (IJ) was called due to the facility failing to ensure an environment free of hazards when an employee (RN Employee E1) entered the facility with a shot gun and ammunition. The NHA was provided with an Immediate Jeopardy template, and a corrective action plan was requested. On 7/16/26, at 3:00 p.m. an acceptable Corrective Action Plan was received which included the following interventions: The facility will create an environment free of potential accidents. The facility cannot retroactively correct the concern identified for the incident that occurred on 7/15/26. Actions:-Employee was notified to remove gun immediately from facility. -Employee received Final Warning discipline from Director of Nursing on 7/15/26 and educated by the DON and NHA on workplace violence and no tolerance for weapons. -All residents will be assessed for injuries, or any psychosocial or mental harm related to (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many Note: The nursing home is disputing this citation.	the incident by Nursing/designee by 7/17/26.-Any resident who had a negative effect will have a care plan and orders updated, family notification and receive any needed services by 7/17/26.-All residents' families and physicians will be notified by SSD/designee by 7/17/26, of the event.-Facility policy and procedure will be updated accordingly by NHA/designee by 7/17/26.-Determine the root cause of the event by 7/17/26.-Educate all facility staff and agency staff on policy regarding violence in the workplace and the definitions of acts of violence and weapons, and the procedure for emergency situations such as a weapon in the facility by 7/17/26.-The facility will develop a proper screening process for all staff/visitors to prevent weapons entering the facility by 7/17/26.-Notices will be posted by receptionist/designee at entrance doors indicating weapons are not permitted on facility property by 7/17/26-Educate if a staff member identifies a weapon entering the facility they are to notify their supervisor or call 911 by 7/17/26.-Review all Quality Assurance Quality Improvement meetings and make additional changes to ensure residents' safety as needed. On 7/17/26, the abatement plan was reviewed for completion as follows:-Employee was notified to remove gun immediately from facility. - verified 7/17/26-Employee received Final Warning discipline from Director of Nursing on 7/15/26 and educated by the DON and NHA on workplace violence and no tolerance for weapons. Verified 7/17/26.-90 of 90 in-house residents were assessed for injuries, or any psychosocial or mental harm related to the incident. Verified 7/17/26.-None of the 90 assessments revealed findings of anxiety, fear or negative effects on residents. Verified 7/17/26.-The Medical Director was notified of the incident relating to all residents on 7/16/26. Verified on 7/17/26.-All families were notified of the incident that occurred on 7/15/26. Verified on 7/17/26.-The facility policy Workplace Violence was reviewed on 7/16/26, by the Administrator and DON. Verified on 7/17/26.-Root caused was identified as lack of education and understanding by staff. Verified 7/17/26.-Education for all facility staff and agency staff regarding violence in the workplace and the definitions of acts of violence and weapons, and the procedure for emergency situations such as a weapon in the facility. Verified trainings on 7/17/26.-Staff signatures on education 58 facility and 49 agency = total of 107 of 115 staff signatures.-In person facility interviews across all disciplines totaling 23 staff and all expressed training and understanding.-The NHA developed a Workplace Violence Screening Policy dated 7/17/26, where all staff and visitors will enter through the front door only. The persons attending the door will ask them if they are in possession of any weapons. The person will be instructed to sign in and out at the desk. The only exception to this entry rule is for 911 services.-Notices posted by receptionist/designee at entrance doors indicating weapons are not permitted on the facility's property. Verified 7/17/26.-The incident will be reviewed at the next Quality Assurance and Performance Improvement Meeting scheduled for 7/21/26. The Immediate Jeopardy was lifted on 7/17/26, at 1:03 p.m. when the action plan implementation was verified. Interview on 7/17/26, at 2:50 p.m. the Nursing Home Administrator and Director of Nursing confirmed the facility failed to ensure an environment free of hazards likely to cause serious injury, harm, impairment, or death when an Employee (RN Employee E1) entered the facility with a shot gun and ammunition. This failure created an immediate jeopardy situation for all residents. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure a physician completed the initial comprehensive visit for two of five residents (Residents R1 and R2). Findings include: Review of Resident R1's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/26/26, indicated diagnoses of high depression, muscle weakness, and difficulty walking. Review of Resident R1's clinical record failed to include documentation that the initial comprehensive visit was completed by a physician. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and insomnia. Review of Resident R2's clinical record failed to include documentation that the initial comprehensive visit was completed by a physician. During an interview on 7/17/26, at 2:21 p.m. the Director of Nursing confirmed that the facility failed to ensure a physician completed the initial comprehensive visit for Residents R1 and R2. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code 211.5(f)(iv) Medical records.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility policy and documents, and staff interviews it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility by failing to ensure an environment free of accidents likely to cause serious injury, harm, impairment, or death when a staff member saw a man walk in with a shot gun and ammunition in his hand. This failure created an immediate jeopardy situation for all residents. Findings include: Based on findings identified in this report the facility failed to ensure an environment free of accidents likely to cause serious injury, harm, impairment, or death when a staff member saw a man walk in with a shot gun and ammunition in his hand, placing all residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 7/17/26, at 2:50 p.m. the NHA and DON were notified that they failed to effectively manage the facility by failing to create a safe environment free of accidents likely to cause serious injury, harm, impairment, or death when a staff member saw a man walk in with a shot gun and ammunition in his hand. This failure created an immediate jeopardy situation for all residents. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(3)(e)(1) Management.		