STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __--_____ B. WING: _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

(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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 18, 2024, at Armstrong Rehabilitation and Nursing Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 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.

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/18/2024

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

Jeanne Parisi
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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: 01 B. WING:	12/18/2024

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K 0000	INITIAL COMMENT Facility ID #530602 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 18, 2024, it was determined that Armstrong Rehabilitation and Nursing 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 483.90(a). This is a five-story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0100 SS=E		K 0100		

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.

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K 0100 SS=E	Continued from page 1 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	1. Maintenance Director immediately removed combustible materials from the basement area. 2. The approval of the state plan review with granted occupancy that was granted on 8/13/24 from the Life Safety Division will be placed in the Emergency Preparedness Binder. An additional request for approval for the change of use of the 5th floor will be submitted to plan review requesting the occupancy change. 3. Maintenance Director or designee will audit for appropriate storage in the basement area weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/31/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0100 SS=E	Continued from page 2 Based on observation and interview, the facility failed to maintain general requirements of the life safety code that are not addressed by specific K-tags, but are deficient, on two of six building levels. Findings include: 1. Observation on December 18, 2024, between 9:15 a.m. and 9:33 a.m., revealed the basement floor seamstress room and mechanical equipment room had been converted to storage locations containing combustible materials. These rooms do not meet hazardous area requirements. The facility changed the use of the rooms without the approval of State Plan Review and a granted occupancy from the Division of Life Safety. Interview with the administrator and maintenance director on December 18, 2024, at 9:33 a.m., confirmed the facility did not submit the required paperwork for the room change of use.	K 0100		

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K 0100 SS=E	Continued from page 3 2. Observation on December 18, 2024, at 12:30 p.m., revealed the facility failed to obtain required approval from the Department of Health State Plan Review and a granted occupancy from Life Safety Division for the change of use of resident rooms to storage rooms on the fifth floor. Interview with the administrator and maintenance director on December 18, 2024, at 12:30 p.m., confirmed the facility did not submit the required paperwork for the room change of use project.	K 0100		
K 0223 SS=D		K 0223		

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K 0223 SS=D	Continued from page 4 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	1. Maintenance Director or designee immediately closed the door in the electrical room and basement laundry door. 2. The latches in the maintenance shop door, maintenance shop paint storage room, housekeeping storage, mechanical equipment room, stair tower C-2 fire door, basement kitchen door, and laundry emergency supply room door will be replaced on repaired on or before 1/14/2025. 3. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining closed doors with self-closing devices. 4. Maintenance Director or designee will audit for self-closing doors in the basement area weekly x 4 weeks and monthly x 1 month. 5. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0223 SS=D	Continued from page 5 Based on observation and interview, the facility failed to maintain doors with self-closing devices for one of five floors. Findings include: Observation on December 18, 2024, between 9:03 a.m. and 10:32 a.m., revealed the following self-closing door deficiencies: A. (9:03 a.m.) Basement electrical equipment room B-2 door was held open with a wooden box, preventing the door from closing and latching; B. (9:13 a.m.) Basement maintenance shop storage room door failed to latch in the frame; C. (9:15 a.m.) Basement seamstress room door was held open, preventing the door from closing and latching; D. (9:21 a.m.) Basement maintenance shop paint storage room door had closure mechanism disconnected/broken from the frame, preventing the door from self-closing; E. (9:36 a.m.) Basement housekeeping storage room door failed to latch in the frame;	K 0223		

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K 0223 SS=D	Continued from page 6 F. (9:49 a.m.) Basement mechanical equipment room rear double door failed to latch in the frame; G. (10:01 a.m.) Basement stair tower C-2 fire door failed to latch in the frame; H. (10:26 a.m.) Basement kitchen door had one of two leaves fail to latch in the frame: I. (10:32 a.m.) Laundry emergency supply room doors failed to latch in the frame. Interview with the maintenance director on December 18, 2024, at 10:32 a.m., confirmed the self-closing door deficiencies.	K 0223		
K 0293 SS=B		K 0293		

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K 0293 SS=B	Continued from page 7 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	1. Maintenance Director or designee immediately repaired or replaced three exit signs. 2. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining exit signs with directionals. 3. Maintenance Director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0293 SS=B	Continued from page 8 Based on observation and interview, the facility failed to maintain exit signs for three of over forty signs. Findings include: Observation on December 18, 2024, between 9:41 a.m. and 12:15 p.m., revealed the following exit sign deficiencies: A. (9:41 a.m.) Basement corridor outside the unit clerk room had a missing directional exit sign, breaking continuity; B. (11:36 a.m.) Basement laundry, near sort room, had a missing directional exit sign, breaking continuity; C. (12:15 p.m.) Second floor, near nurse station 2-BD, had a missing directional exit sign, breaking continuity. Ref: NFPA 101 7.10 Interview with the maintenance director on December 18, 2024, at 12:15 p.m., confirmed the	K 0293		

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K 0293 SS=B	Continued from page 9 missing exit signs at the time of the survey.	K 0293		
K 0345 SS=C	NFPA 101 Fire Alarm System - Testing and Maintenance 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 This REQUIREMENT is not met as evidenced by:	K 0345	1. Maintenance Director or designee immediately repaired the time/date on the fire control panel. 2. Education will be provided to the maintenance department by Administrator or designee on the importance accuracy on the fire control panel. 3. Maintenance Director or designee will audit monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0345 SS=C	Continued from page 10 Based on observation and interview, the facility failed to maintain the fire control panel for one of one component. Findings include: Observation on December 18, 2024, at 9:00 a.m., revealed the main fire control panel displayed an incorrect date and time at the time of the survey. The panel displayed "9:26:24 PM TUE 17 DEC 24." Interview with the maintenance director on December 18, 2024, at 9:00 a.m., confirmed the time clock deficiency.	K 0345		
K 0353 SS=B		K 0353		

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K 0353 SS=B	Continued from page 11 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	1. The laundry room sprinkler heads were both immediately cleaned. 2. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining sprinkler heads. 3. The maintenance director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0353 SS=B	Continued from page 12 Based on observation and interview, the facility failed to maintain the sprinkler system for two of over thirty sprinkler heads. Findings include: Observation on December 18, 2024, at 10:37 a.m., revealed the basement laundry sorting room had two sprinkler heads covered with a layer of dust/lint. A build-up of material can insulate the sprinkler thermal element, impacting the temperature activation/response time of the sprinkler and/or causing inadequate spray coverage. Interview with the maintenance director on December 18, 2024, at 10:37 a.m., confirmed the sprinkler head deficiency.	K 0353		
K 0372 SS=E		K 0372		

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K 0372 SS=E	Continued from page 13 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	1. The smoke barriers, ceiling tiles, grid system, will be repaired on or before 1/14/2025. 2. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining smoke barrier standards. 3. Maintenance Director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0372 SS=E	Continued from page 14 Based on observation and interview, the facility failed to maintain smoke barrier requirements on two of five floors. Findings include: Observation on December 18, 2024, between 9:04 a.m. and 12:22 p.m., revealed the facility failed to maintain smoke barriers in numerous rooms, including storage, mechanical, electrical, oxygen storage, corridors, and other rooms. Ceiling tiles were found to be missing, broken, misaligned, sagging, deteriorated, and not fitting into the grid system. The grid system was found to be missing grid work and was in disrepair in several areas and not supporting the ceiling tiles. These conditions would allow the transfer of smoke. Interview with the maintenance director on December 18, 2024, at 12:22 p.m., confirmed the smoke barrier deficiencies.	K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395471	A. BLDG: __01_____ B. WING: _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **530602**	**265 S MCKEAN STREET KITTANNING, PA 16201**

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K 0753 SS=B	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by:	K 0753	1. Maintenance Director or designee immediately removed combustible decorations from three doors. 2. Education will be provided to the maintenance department by Administrator or designee on the potential hazards with combustible decorations. 3. Maintenance Director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0753 SS=B	Continued from page 16 Based on observation and interview, the facility failed to maintain combustible decorations on three of over fifty corridor doors. Findings include: Observation on December 18, 2024, between 12:45 p.m. and 1:05 p.m., revealed the facility had posters covering more than 30% of the door area in multiple locations: A. (12:45 p.m.) Third floor, resident room 316; B. (1:00 p.m.) Second floor, bathroom door next to nurses station; C. (1:05 p.m.) Second floor, soiled utility room door. Interview with the administrator and maintenance director on December 18, 2024, at 1:05 p.m., confirmed the combustible decoration deficiencies.	K 0753		
K 0761 SS=F		K 0761		

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K 0761 SS=F	Continued from page 17 NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	1. Administrator or designee will ensure a smoke and fire door inspection is completed on or before 1/14/2025. 2. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining annual smoke and fire door inspections. 3. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0761 SS=F	Continued from page 18 Based on document review and interview, the facility failed to maintain, inspect, and test fire doors, in accordance with regulations, affecting the entire building. Findings include: Document review on December 18, 2024, at 10:20 a.m., revealed the last smoke and fire door annual inspection was conducted July 11, 2023. Interview with the administrator and maintenance director on December 18, 2024, at 10:20 a.m., confirmed more-recent door inspection documentation was unavailable at the time of the survey.	K 0761		
K 0911 SS=B		K 0911		

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K 0911 SS=B	Continued from page 19 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	1. The items in the basement storage room blocking the electrical panel were immediately moved. The cover plate in the electrical outlet in the basement employee dining room was immediately repaired. 2. Education will be provided to the maintenance department by Administrator or designee on maintaining electrical system requirements. 3. Maintenance Director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable. K912	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0911 SS=B	Continued from page 20 Based on document review and interview, the facility failed to maintain electrical system requirements in two of over twenty-five rooms. Findings include: Observation on December 18, 2024, between 9:22 a.m. and 9:46 a.m., revealed the following locations had blocked access to the electric panels: A. (9:22 a.m.) Basement storage room had miscellaneous items blocking access to the electric panels; B. (9:46 a.m.) The basement employee dining room had an unprotected electrical outlet that was missing the cover plate. Interview with the maintenance director on December 18, 2024, at 9:46 a.m., confirmed the electric panel deficiencies.	K 0911		

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K 0912 SS=B	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	1. The GFCI's in six receptacles will be installed or repaired by 1/14/2025. 2. Education will be provided to the maintenance department by Administrator or designee on ensuring ground fault circuit interrupter protection within six feet of water sources. 3. Maintenance Director or designee will audit weekly x 4 weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0912 SS=B	Continued from page 22 Based on observation and interview, the facility failed to maintain electrical receptacles for six of more than fifty receptacles. Findings include: Observation on December 18, 2024, between 9:36 a.m. and 12:20 p.m., revealed the facility failed to ensure ground fault circuit interrupter (GFCI) protection in the following areas within six feet of water sources: 1. (9:36 a.m.) Basement housekeeping storage room had an unprotected receptacle within six feet of the sink; 2. (10:15 a.m.) Basement kitchen food prep area, over sink basin; 3. (10:20 a.m.) Basement kitchen food prep area, side wall near the sink;; 4. (10:33 a.m.) Laundry washer area, deep sink; 5. (11:20 a.m.) First floor hostess shoppe, food prep sink; 6. (11:45 a.m.) First floor corridor, near female rest room, water fountain;	K 0912		

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K 0912 SS=B	Continued from page 23 7. (12:20 p.m.) Second floor corridor, near resident room #213. Interview with the maintenance specialist on December 18, 2024, at 12:20 p.m., confirmed the electrical outlet deficiencies.	K 0912		
K 0918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste 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	K 0918	1. Maintenance Director will ensure the breaker was replaced on the 80GS60 generator, allowing it to pass the three- year, four-hour load test by 1/14/2025. 2. Education will be provided to the maintenance department by Administrator or designee on the importance of maintaining the emergency generator. 3. Maintenance Director or designee will audit monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0918 SS=E	Continued from page 24 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 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

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K 0918 SS=E	Continued from page 25 Based on document review and interview, the facility failed to maintain the emergency generator for one of two generators. Findings include: Document review on December 18, 2024, at 10:55 a.m., revealed the 80GS60 generator failed the three-year, four-hour load test due to a bad breaker. The facility failed to provide updated documentation after the breaker was replaced. Interview with the administrator and maintenance director on December 18, 2024, at 10:55 a.m., confirmed the emergency generator deficiency.	K 0918		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 26 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	1. The combustible storage was immediately moved outside of five feet from the oxygen cylinders and oxygen cylinders were separated based on filled/empty amounts in three areas. 2. Education will be provided to the maintenance department by Administrator or designee on the regulations related to oxygen storage. 3. Maintenance Director or designee will audit weekly x four weeks and monthly x 1 month. 4. Results will be discussed with QA committee with monitoring if applicable.	Completion Date: **01/14/2025** Status: **APPROVED** Date: **01/09/2025**

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K 0923 SS=E	Continued from page 27 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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K 0923 SS=E	Continued from page 28 Based on observation and interview, the facility failed to maintain gas equipment storage in three of three oxygen storage areas. Findings include: Observation on December 18, 2024, between 9:27 a.m. and 12:19 p.m., revealed the following deficiencies: 1. (9:27 a.m.) Basement housekeeping storage room, across from women's locker room, had combustible storage within five feet of the oxygen cylinders. The oxygen cylinders were also not separated based on filled/empty amounts; 2. (9:39 a.m.) Basement unit clerk room had combustible storage within five feet of the oxygen cylinders. The oxygen cylinders were also not separated based on filled/empty amounts; 3. (12:19 p.m.) Second floor, across from resident room #213, had combustible storage within five feet of the oxygen cylinders. The oxygen cylinders were also not separated based on filled/empty amounts.	K 0923		

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K 0923 SS=E	Continued from page 29 Interview with the maintenance specialist on December 18, 2024, at 12:19 p.m., confirmed the gas equipment storage deficiencies.	K 0923		

Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 12/18/2024

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

Jeanne Parisi
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