

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET KITTANNING, PA 16201 | | |
| STATE LICENSE NUMBER: 530602 | | | | |
| (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 Based on an Onsite Revisit to 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: 02/05/2025

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: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 |
|--------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------|

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

| (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 0000 | <p>INITIAL COMMENT</p> <p>Facility ID # 530602 Component 01 Main Building</p> <p>Based on an Onsite Revisit to 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).</p> <p>This is a five-story, Type II (222), fire resistive building, with a 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET KITTANNING, PA 16201 | | |
| STATE LICENSE NUMBER: 530602 | | | | |
| (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 0100 SS=E | 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 | A plan review will be submitted to life safety on the website for a room change. 2. Maintenance Director or designee will audit for appropriate storage in the basement area weekly x 4 weeks and monthly x 1 month 3. Results will be reviewed with the QA committee with monitoring if applicable | Completion Date: 03/10/2025 Status: APPROVED Date: 02/27/2025 |
| | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET KITTANNING, PA 16201 | | |
| STATE LICENSE NUMBER: 530602 | | | | |
| (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 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. 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 | K 0100 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 | |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 530602 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET 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 0100 SS=E | Continued from page 3 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. ***** Based on observation and interview during an Onsite Revisit Survey conducted on February 5, 2025, at 10:25 a.m., it was determined that the facility failed to submit a narrative with plans to the Division of Safety Inspection Plan Review for the projects at the time of the Revisit Survey. A letter was provided stating that contact was made to the Division of Nursing Care Facilities regarding the fifth floor storage. However, notification for change of use or storage usage will need submitted to Plan Review for approval. Interview with the administrator and the maintenance supervisor on February 5, 2025, at 10:25 a.m., confirmed the facility was not completed with the | K 0100 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 |
|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET KITTANNING, PA 16201 | | |
| STATE LICENSE NUMBER: 530602 | | | | |
| (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 0100 SS=E | Continued from page 4 deficiencies at the time of the Revisit Survey. | K 0100 | | |
| 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 | K345 1. The process for repairing the fire alarm has been started and is in the final steps for approval with additional parts being ordered after that. 2. Once fire panel is repaired, Maintenance Director or designee will monitor for appropriate operation and continue monthly fire drills as required. 3. Results will be reviewed with the QA committee with monitoring if applicable | Completion Date: 03/10/2025 Status: APPROVED Date: 02/27/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 | |
|--------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 530602 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET 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 0345 SS=C | Continued from page 5 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. ***** Based on observation and interview during an Onsite Revisit Survey conducted on February 5, 2025, at 11:02 a.m., it was determined that the fire alarm panel indicated a trouble signal. It was communicated that the facility experienced a broken water line above the panel, causing internal damage, initiating the trouble signal. The facility implemented a fire watch, contacted the vendor to repair the panel ,and parts were on order at the time of the | K 0345 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471 | (X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED: 02/05/2025 | |
|--------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------|
| NAME OF PROVIDER OR SUPPLIER: ARMSTRONG REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: 530602 | | STREET ADDRESS, CITY, STATE, ZIP CODE: 265 S MCKEAN STREET 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 0345 SS=C | Continued from page 6 Revisit Survey. However, the facility had no timeline for the repairs to be completed. Interview with the administrator and the maintenance supervisor on February 5, 2025, at 11:02 a.m., confirmed the facility was not completed with the deficiencies at the time of the Revisit Survey. | K 0345 | | |



Certified End Page

ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 02/05/2025

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