

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395471	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 08/12/2025
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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
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(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
P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>The residents had no negative outcome from staffing pattern mentioned in cited survey</p> <p>The NHA or designee will provide the scheduler with education on Pennsylvania staffing requirements for nurse aide ratios</p> <p>Daily labor calls and meeting are held to look at schedule ahead of time to make sure scheduling needs are met. Increase recruitment for new hires will start.</p> <p>Staffing coordinator or designee will audit the ratios weekly times 4 weeks and monthly times 1 month. Results of audits will be submitted to QAPI committee for tracking and further recommendations</p>	<p>Completion Date: 09/11/2025</p> <p>Status: APPROVED</p> <p>Date: 08/29/2025</p>

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

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P 5520	Continued from page 1 Based on a review of staffing documents provided by the facility and staff interview, it was determined that the facility failed to provide one nurse assistant (NA) per 15 residents on the night shift on one of seven days (8/7/25) as required. Findings include: A review of facility staffing documents provided by the facility from 8/5/25 through 8/11/25, revealed the facility failed to provide NA on the following shift as required: Night shift: <table border="1"> <thead> <tr> <th>Date</th> <th>Census</th> <th>Actual hours</th> <th>Hours required</th> </tr> </thead> <tbody> <tr> <td>8/7/25</td> <td>94</td> <td>36.70</td> <td>47.00</td> </tr> </tbody> </table> During an interview on 8/12/25 at 11:40 a.m., the Nursing Home Administrator confirmed that the	Date	Census	Actual hours	Hours required	8/7/25	94	36.70	47.00	P 5520		
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8/7/25	94	36.70	47.00									

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P 5520	Continued from page 2 facility failed to provide NA's in the facility on the above shift as required.	P 5520			



Certified End Page

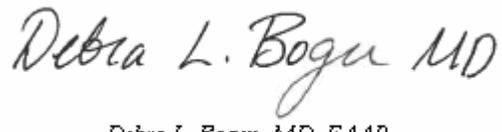
ARMSTRONG REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 530602

SURVEY EXIT DATE: 08/12/2025

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